National Elevator Industry Health Benefit Plan

Summary Plan Description

National Elevator Industry Health Benefit Plan

National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073

June 2015

Dear Member,

The Board of Trustees of the National Elevator Industry Health Benefit Plan is pleased to issue this revised National Elevator Industry Health Benefit Plan Summary Plan Description. This is the official Plan of Benefits adopted by the Trustees in accordance with their authority under the Restated Agreement and Declaration of Trust of the National Elevator Industry Health Benefit Plan. It has been written to reflect the changes in the written Plan of Benefits since the last version of the Plan of Benefits was issued.

Your Plan of Benefits includes:

- Comprehensive medical care, including great wellness benefits;
- Mental health and substance abuse treatment benefits;
- Prescription drug benefits, including a mail order program;
- Vision care benefits, including a benefit toward LASIK vision correction surgery;
- Hearing care benefits, and a benefit toward the purchase of a hearing aid;
- Dental care benefits, including Orthodontia for all covered Participants;
- Weekly income benefits; and
- Life insurance and accidental death and dismemberment insurance.

We encourage you and your family to read this Summary Plan Description carefully to make the best use of the benefits the National Elevator Industry Health Benefit Plan offers.

This Summary Plan Description (or Plan of Benefits) provides the required information about your rights and protection under the law in order to comply with the Employee Retirement Income Security Act of 1974 (ERISA), the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) and other federal laws.

Grandfathered Status under the ACA

The National Elevator Industry Health Benefit Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Health Benefit Plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on “essential health benefits” as defined by federal law.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Board of Trustees of the National Elevator Industry Health Benefit Plan, c/o Robert O. Betts, Jr., 19 Campus Blvd, Suite 200, Newtown Square, PA 19073-3288, (800) 523-4702. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Benefits Office of the National Elevator Industry Benefit Plans at 1-800-523-4702.

Sincerely Yours,

The Board of Trustees

NOTE: Over time, it may be necessary to change the eligibility rules and benefits provided by the Plan. In accordance with the Restated Agreement and Declaration of Trust of the National Elevator Industry Health Benefit Plan, the Trustees, in their sole discretion, have the authority to change, modify, or discontinue all or part of the eligibility rules or benefits at any time. Whenever the Plan provides that certain policies (such as self- payment rates, benefits provided, etc.) are set by the Trustees, these policies will be on file at the Benefits Office. If you have any questions, contact the Benefits Office.

Board of Trustees

The Board of Trustees is made up of an equal number of Employer Trustees and Union Trustees. The Trustees serve without compensation. The Trustees have complete discretion and authority to control and manage the operation and administration of the National Elevator Industry Health Benefit Plan. They also have exclusive authority to interpret the terms of this Plan of Benefits.

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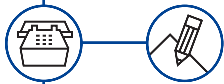
Important Contact Information



You can always call the Benefits Office if you have a question about your Health Benefit Plan. Here are some phone numbers and websites to help you get answers to your questions quickly. Remember, have your Member Identification Number available when you make a call.

FOR INFORMATION ABOUT	CONTACT	PHONE NUMBER	WEBSITE
Life Insurance/Weekly Income	Benefits Office	1-800-252-4611	www.neibenefits.org
Medical Claims Member Services	Benefits Office	1-800-252-4611	www.neibenefits.org
Dental/Vision Member Services	Benefits Office	1-800-252-4611	www.neibenefits.org
Hearing Aid/Ear Care	AudioNet America	1-855-800-7147	www.Audionetamerica.com
Medical Care PPO Network	Blue Cross Blue Shield	1-800-810-BLUE	www.bcbs.com
Dental Care PPO Network	The Guardian	1-888-600-9200	www.guardianlife.com
Mental Health/Substance Abuse	Beacon Health Options	1-800-331-4824	www.achievesolutions.net
Precertification	Carewise Health	1-800-634-4832	
Prescriptions—Pharmacy	Express Scripts	1-866-830-3890	www.express-scripts.com
Prescriptions—Home Delivery	Express Scripts	1-866-830-3890	www.express-scripts.com
Vision Care	EyeMed	1-877-226-1115	www.eyemedvisioncare.com
Social Security Disability	Allsup, Inc.	1-800-383-2495	www.allsupinc.com

ADDRESSES

■ Non-Network Medical Claims	NEI Health Benefit Plan P.O. Box 477 Newtown Square, PA 19073
■ Medicare Primary Claims	NEI Health Benefit Plan P.O. Box 910 Newtown Square, PA 19073
■ Dental Claims	NEI Health Benefit Plan P.O. Box 475 Newtown Square, PA 19073
■ Non-Network Vision Claims ■ Weekly Income Claims	NEI Health Benefit Plan P.O. Box 476 Newtown Square, PA 19073
■ Life Insurance Claims ■ AD&D Claims ■ Enrollment Forms ■ Address Changes ■ Beneficiary Forms ■ Eligibility Issues ■ COBRA/EB Payments ■ Qualified Medical Child Support Orders (QMCSOs) ■ National Medical Support Notices	NEI Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073

Schedule of Health Benefits

The National Elevator Industry Health Benefit Plan offers eligible Plan members and their families a comprehensive health care plan. You can find the specific details of each benefit throughout the SPD. Please see the table of contents to find the details of each of the listed benefits.

WEEKLY INCOME, LIFE INSURANCE AND AD&D BENEFITS

Only Active Members engaged in covered employment are eligible to receive Weekly Income Benefits. Dependents, Disabled or laid-off Employees covered under the Plan's extended benefit provisions and Retirees are not eligible to receive Weekly Income Benefits.

Life insurance and AD&D benefits are payable on behalf of all eligible Active Members and eligible Disability Retirees in receipt of a Disability Pension from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan who are under age 65.

WEEKLY INCOME, LIFE AND AD&D BENEFITS	
Weekly Income Benefit	$500 per week for up to 26 weeks*
Life Insurance	$40,000 benefit for your designated beneficiary
Accidental Death and Dismemberment (AD&D)	$40,000 benefit for your beneficiary for your accidental death (in addition to the life insurance benefit above). $40,000 benefit for you for loss of both hands, both feet or sight in both eyes $40,000 benefit for you for loss of any combination of one foot, one hand or sight in one eye $20,000 benefit for you for loss of one hand or one foot $20,000 benefit for you for the loss of sight in one eye

*Note: Benefits may be different in NY, NJ and HI.

WHO IS AN "ACTIVE MEMBER?"

An Active Member is an Employee who is either working in covered employment for an Employer in the Elevator Industry who makes contributions to the Health Benefit Plan on the member's behalf or an Employee who is disabled or laid-off and continues to maintain eligibility for benefits in accordance with the Plan's extended benefits provisions.

MEDICAL BENEFITS

You and your covered dependents are eligible for most medical benefits. The network provider for your medical benefits is the Blue Cross Blue Shield BlueCard PPO Program. The chart below shows the amount of your coinsurance and after you've met your annual deductible.

MEDICAL BENEFITS	
Your Annual Medical Deductible	$300 per person; $600 per family
Your Annual Out-of-Pocket Maximum (includes annual deductible but does not include non-covered services or amounts in excess of UCR)	In-Network—$300 per person; $600 per family Out-of-Network—$1,500 per person; $3,000 per family (includes Out-of-Network Mental Health and Substance Abuse Treatment) Out-of-Area—$300 per person; $600 per family
Lifetime Maximum Benefit the Plan will pay	There is no cap on benefits for most covered expenses; however, limits may apply to certain services.

If you visit a provider in the Blue Cross Blue Shield BlueCard PPO Program, covered medical expenses are paid at 100% of the "contracted rate"—a rate that PPO providers have agreed to accept from the Plan as payment in full—after you've met your annual deductible.

If you do not live out-of-area (see below) and you visit an out-of-network provider, the Plan only pays for covered medical expenses at 75% of the Usual, Customary, and Reasonable (UCR) Rate, after you've met your deductible. You are responsible for paying the other 25%, as well as any amount your out-of-network provider charges that is more than the UCR amount. For more information, see "How Your Medical Plan Works" on page 32.

If you live in an area where there are not many PPO providers, you may be considered "out-of-area". Covered Individuals who are considered out-of-area will receive a higher level of benefits when they visit out-of-network providers. Typically, out-of-area expenses are paid at 100% of the UCR Rate for Covered Individuals who are out-of-area, after you've met your deductible. You are responsible for paying any amount that your out-of-area provider charges that exceeds the UCR amount.

	You Pay In-Network **Paid at the Contracted Rate**	**You Pay Out-of-Network** **Paid at the UCR Rate***
Acupuncture Services	$0 (after deductible) when performed by an M.D., LaC or D.O. only	25% of the UCR Rate (after deductible) when performed by an M.D. , D.O. , R.N., N.P., C.N.P., R.N.P. or provider certified by the National Certification Commission for Acupuncture and Oriental Medicine.
Ambulance Service	$0 (after deductible)	100% of amount over UCR (after deductible)
Anesthesia	$0 (after deductible)	100% of amount over UCR (after deductible)
Chiropractic Care (visits are per calendar year)	Visit 1-12 $0 (after deductible) Visit 13-24 25% of Allowed Amount (after deductible) Visit 25-36 50% of Allowed Amount (after deductible) Visit 37+ 75% of Allowed Amount (after deductible)	Visit 1-12 25% of the UCR Rate (after deductible) Visit 13-24 50% of the UCR Rate (after deductible) Visit 25-36 75% of the UCR Rate (after deductible) Visit 37+ No coverage
Diagnostic Laboratory and X-Ray	$0 (after deductible)	25% of the UCR Rate (after deductible)
Durable Medical Equipment	$0 (after deductible)	25% of the UCR Rate (after deductible)
Emergency Room	$50 Copay; $0 (after deductible)	$50 Copay; 100% of amount over the UCR Rate (after deductible)
Hearing Aids (benefit limits apply)	$0	N/A
Hospice Care	$0 (after deductible)	25% of the UCR Rate (after deductible)
Home Health Care	$0 (after deductible) up to 80 visits per calendar year	25% of the UCR Rate (after deductible) up to 80 visits per calendar year
Infertility Treatment	$0 (after deductible)	25% of the UCR Rate (after deductible)
Inpatient Rehabilitation Facility	$0 (after deductible)	25% of the UCR Rate (after deductible)
Skilled Nursing Services	$0 (after deductible)	25% of the UCR Rate (after deductible)
Office Visits (Personal Physician)	$0 (after deductible)	25% of the UCR Rate (after deductible)
Office Visits (Specialist)	$0 (after deductible)	25% of the UCR Rate (after deductible)
Organ Transplants	$0 (after deductible)	25% of the UCR Rate (after deductible)
Physical Exams (frequency limits apply)	$0 (no deductible)	25% of the UCR Rate (after deductible)
Physical and Occupational Therapy (Outpatient)	$0 (after deductible)	25% of the UCR Rate (after deductible)
Speech Therapy (benefit limits apply)	$0 (after deductible)	25% of the UCR Rate (after deductible)
Surgical Expenses	$0 (after deductible)	25% of the UCR Rate (after deductible)
Well-Baby Care (benefit limits apply)	$0 (no deductible)	25% of the UCR Rate (after deductible)

**plus the amount in excess of UCR*

DENTAL BENEFITS

You and your eligible dependents are eligible for dental benefits. The Plan's network dental provider is Guardian. The chart below shows the Plan's annual deductible for dental benefits, the Plan's applicable annual and Lifetime Maximums, and the amount of your coinsurance after you've met the annual deductible. If you visit an in-network (Guardian DentalGuard Preferred Select PPO) provider, you are only responsible for amounts applied to your deductible and coinsurance. You cannot be balance billed for amounts above the contracted rate.

If you visit an out-of-network provider for dental care, benefits are paid at the UCR Rate. You must pay any amount your out-of-network provider charges that exceeds the UCR Rate, in addition to any annual deductible and your coinsurance.

DENTAL BENEFITS		
Annual Deductible (Does not apply to preventive and diagnostic services)	$50 per person or $100 per family	
Annual Maximum Amount the Plan Will Pay	$1,875 for Type II and Type III services (excluding Orthodontia). Type I services and pediatric dental services are not subject to Annual Maximum.	
Lifetime Maximum Amount the Plan Will Pay for Orthodontia	Up to $2,500 per Covered Individual. Lifetime Maximum does not apply to pediatric Medically Necessary Orthodontia.	
Lifetime Temporomandibular Joint Dysfunction Benefit	$1,500 per Covered Individual	
	You Pay In-Network	**You Pay Out-of-Network**
Exams*	$0	100% of amount over UCR Rate
Cleanings*	$0	100% of amount over UCR Rate
X-Rays*	$0	100% of amount over UCR Rate
Fluoride*	$0	100% of amount over UCR Rate
Sealants*	$0	100% of amount over UCR Rate
Fillings	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Oral Surgery	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Periodontics	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Denture Repairs	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Crowns & Inlays	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Full or Partial Dentures or Bridges	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Implants	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Braces (Orthodontics)	Up to $2,500 paid in installment payments every 90 days for up to two years while receiving active treatment ($2,500 Lifetime Maximum does not apply to pediatric medically-necessary Orthodontia).	

** Services do not apply to Annual Dental Benefit Maximum.*

MENTAL HEALTH TREATMENT BENEFITS

You and your eligible dependents are eligible for mental health treatment benefits. The Plan's network provider for mental health treatment is Beacon Health Options. The chart below shows the amount of your coinsurance.

If you visit an in-network provider, benefits are paid in full, and you cannot be balance billed for amounts above the contracted rate. If you visit an out-of-network provider, benefits are paid at the UCR Rate, and you must pay any amount your out-of-network provider charges that exceeds the UCR Rate in addition to your coinsurance.

MENTAL HEALTH TREATMENT BENEFITS

	Precertification Required		You Pay In-Network	You Pay Out-of-Network
	In-Network	Out-of-Network		
Inpatient Hospitalization and Alternative Levels of Care	Yes	Yes	$0	25% of UCR Rate, plus, if applicable, 100% of the charge in excess of the UCR Rate
Inpatient Therapy/Hospital Visits/ Psych Consults	Yes	Yes	$0	25% of UCR Rate, plus, if applicable, 100% of the charge in excess of the UCR Rate
Inpatient Psychological Testing	Yes	Yes	$0	25% of UCR Rate, plus, if applicable, 100% of the charge in excess of the UCR Rate
Outpatient Mental Health Therapy	Yes	No	$0	25% of UCR Rate, plus, if applicable, 100% of the charge in excess of the UCR Rate
Outpatient Psych Testing	Yes	No	$0	25% of UCR Rate, plus, if applicable, 100% of the charge in excess of the UCR Rate

SUBSTANCE ABUSE TREATMENT BENEFITS

You and your eligible dependents are eligible for substance abuse treatment benefits. The Plan's network provider for substance abuse treatment is Beacon Health Options. The chart on the next page shows the amount of your coinsurance.

If you visit an in-network provider, benefits are paid in full, and you cannot be balance billed for amounts above the contracted rate. If you visit an out-of-network provider, benefits are paid at the UCR Rate, which means that you must pay any amount your out-of-network provider charges that exceeds the UCR Rate in addition to your coinsurance.

SUBSTANCE ABUSE TREATMENT BENEFITS	Precertification Required		You Pay In-Network	You Pay Out-of-Network
	In-Network	Out-of-Network		
Inpatient Hospitalization and Alternate Levels of Care	Yes	Yes	$0	25% of UCR Rate plus, if applicable, 100% of the charge in excess of the UCR Rate.
Inpatient Therapy/Hospital Visits	Yes	Yes	$0	25% of UCR Rate plus, if applicable, 100% of the charge in excess of the UCR Rate.
Inpatient Psychological Testing	Yes	Yes	$0	25% of UCR Rate plus, if applicable, 100% of the charge in excess of the UCR Rate.
Outpatient Substance Abuse Therapy	Yes	No	$0	25% of UCR Rate plus, if applicable, 100% of the charge in excess of the UCR Rate.

PRESCRIPTION DRUG BENEFITS

You and your eligible dependents are eligible for Prescription Drug benefits. The network provider for Prescription Drugs is Express Scripts.

PRESCRIPTION DRUG BENEFITS	You Pay In-Network
Generic Drugs (Retail Pharmacy) (maximum Retail co-pay is $40)	20% of amount charged with a minimum Copayment of $5 for a 30-day supply
Preferred Brand Name Drugs (Retail Pharmacy) (maximum Retail co-pay is $40)	20% of amount charged with a minimum Copayment of $15 for a 30-day supply
Non Preferred Brand Name Drugs (Retail Pharmacy) (maximum Retail co-pay is $40)	20% of amount charged with a minimum Copayment of $30 for a 30-day supply
Generic Drugs (Home Delivery)	$10 Copayment for a 90-day supply
Preferred Brand Name Drugs (Home Delivery)	$30 Copayment for a 90-day supply
Non Preferred Brand Name Drugs (Home Delivery)	$50 Copayment for a 90-day supply

NOTE: Retirees whose pensions became effective on or before January 1, 1984 are eligible for Prescription Drug benefits as follows: $5 Copayment for generic drugs or $10 Copayment for brand name drugs for a 30-day supply from a retail pharmacy; or $10 Copayment for generic drugs or $20 Copayment for brand name drugs for a 90-day supply through the mail order program.

OUT-OF-NETWORK PHARMACIES

Very few pharmacies are considered "out-of-network." If your pharmacy does not participate in the Express Scripts network, you must pay your pharmacy directly and file a claim with Express Scripts.

Express Scripts will send you a reimbursement check for your prescription medication, minus your Copayment. *See page 46 for more information.*

Eligibility for Health Benefits Coverage

FAST FACTS:

- **When you meet the eligibility requirements, you and your eligible family members are covered under the Plan.**
- **Your eligibility is contingent upon payment by your Employer of contributions to the Plan on your behalf. If your Employer does not make the required contributions as they become due, you will lose your eligibility for benefits.**

INITIAL ELIGIBILITY

Generally, you will first be eligible for coverage under the Plan on the first day of the month after you've completed at least 100 hours of work in each of six 30-day periods. The six 30-day periods do not have to be continuous, but they must occur within a nine-month period.

If you do not meet the hours requirement above, but have been employed for at least six months, you will be eligible for coverage under the Plan on the first day of the month after you've completed 1,000 hours of work in any period of 12 consecutive months.

Once you become eligible, your eligible family members are also eligible for coverage under the Plan. To find out if your family members are eligible, see "Eligibility for Dependents" on page 14.

Cost for Coverage

Your Employer makes contributions on your behalf. You are only required to make direct payments to the Benefits Office for coverage if you:

- Are temporarily laid-off (see page 13);
- Become disabled (see page 29);
- Become a Retiree (see page 16);
- Are continuing your coverage under COBRA (see page 19); or
- Are continuing your coverage under USERRA (see page 27).

The Trustees may establish procedures that would allow an employee to establish initial eligibility earlier than otherwise provided under these rules; provided, any modification to these initial eligibility rules does not conflict with the terms of the Trust Agreement, collective bargaining agreement or applicable law. Any modification of these initial eligibility rules must be set forth in a written agreement between the Employer and the IUEC.

Your Employer must pay hourly contributions on your behalf to the Plan as they become due in order for you to be eligible for coverage under the Plan.

CONTINUING YOUR ELIGIBILITY

80/160/300 Rolling Hours Test

You must work at least 80 hours in a calendar month to continue to be eligible for coverage in the month *following* the next calendar month. The month in between is called the "lag month." For example, if you work 80 hours in January, you'll be eligible for coverage in March. February is considered the lag month.

If you do not meet the 80 hours test, but you work a total of 160 hours or more in the two calendar months preceding the lag month, you are eligible for coverage in the calendar month following the lag month. For example, if you work 90 hours in January and 70 hours in February, you'll be eligible for coverage in April. In this example, March is considered the lag month.

If you do not meet the 160 hours test, but you work a total of 300 hours or more in the three calendar months preceding the lag month, you are eligible for coverage in the calendar month following the lag month. For example, if you work 150 hours in January, 75 hours in February and 75 hours in March, you'll be eligible for coverage in May. In this example, April is considered the lag month.

Separate eligibility rules apply to owners and other non-bargaining unit Employees participating in the Plan and Employees of Employers who are covered by participation agreements. Contact the Benefits Office for more information.

The chart below shows how the 80/160/300 rolling hours test works for eligibility for coverage in June.

HOURS WORKED IN COVERED EMPLOYMENT	ELIGIBILITY FOR COVERAGE IN JUNE
April—80 hours or more	Yes
April—less than 80 hours	No
April—less than 80 hours, but March and April combined 160 hours	Yes
April—less than 80 hours, March and April combined less than 160 hours	No
April—less than 80 hours, but February, March and April 300 hours	Yes

EXTENDED BENEFITS

Eligibility Rules for Laid-Off Employees

You may be eligible to continue to receive benefits under the Plan (other than weekly income benefits) if you are laid-off and thereafter continue to satisfy the Plan's eligibility rules for extended benefits as a laid-off Employee. If you maintain your eligibility, you will receive two months of free coverage and thereafter you must make monthly payments to the Benefits Office. You may receive the two-months free coverage only once per layoff and only once in a 12-month period, but an unused month from a prior lay-off may be used in a second lay-off within the same 12 months. (See page 28 for more details about this extended coverage). In addition, once benefits are extended on a self-pay lay-off basis, the basis for extended benefits cannot be changed.

Dependent Eligibility if You Die on the Job or from a Work-Related Injury

If you die while you're covered by the Plan while you're on the job or as a result of a work-related injury, but you had not attained vested status under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan, your eligible dependents may be eligible to continue their coverage. They must elect to continue their coverage within 90 days following the month in which your death occurs. They may continue their coverage at the standard rate available for surviving Spouses under age 65, plus the full rate for dental and vision coverage, if elected. The coverage is available until:

- your Spouse remarries;
- in the case of a dependent Child, he or she is no longer an eligible dependent as defined below;
- your Spouse or dependent Child (as applicable) becomes covered by another health plan;
- your Spouse does not make required monthly contributions to the Plan on time;
- the Trustees modify the provisions of the Plan; or
- the Plan terminates.

If you are not married at the time of your death or your Spouse dies after you, or your Spouse remarries, your eligible dependent Children must elect to continue their coverage within 90 days of your death or, if later, your Spouse's death or remarriage. Your Children may continue their coverage by paying the standard rates applicable for a surviving Spouse under age 65, plus the full rate for dental and vision coverage, if elected. Coverage is available until:

- your dependent Child is no longer an eligible dependent as defined below;
- your dependent Child becomes covered by another health plan;
- your dependent Child or the guardian or representative of your Child does not make the required monthly contributions to the Plan on time;
- the Trustees modify the provisions of the Plan; or
- the Plan terminates.

WHAT IS THE "STANDARD RATE?"

The Standard Rate is posted on the Plan's website www.neibenefits.org. You also will be notified of any changes in the Standard Rate in a Summary of Material Modifications.

However, if you have a vested right to a pension under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan and you die while you're covered by the Plan as an Active Member without a surviving Spouse (or your surviving Spouse subsequently dies) but your eligible dependent Child or Children survive you, they will be eligible to continue their coverage. They (or their guardian or representative) must elect coverage within 90 days following the month in which you or your Spouse dies, whichever is later. Cost for coverage is the standard rate for a surviving Spouse under age 65. They may also elect dental and vision coverage for an additional cost. Note that the Trustees may change the rates for coverage periodically.

Coverage for your eligible dependents will end:

- when your dependents are no longer considered "eligible dependents" by the Plan's definition;
- on the last day of the calendar month in which your dependent Child turns age 26;
- when the Trustees modify the provisions of the Plan;
- when your dependent Child or Children or their guardian or representative fails to make the required monthly contributions on time; or
- when the Plan terminates.

Resuming Eligibility after Military Service

If you leave employment with a participating Employer to serve in the U.S. Armed Forces or National Guard (under federal authority), and meet the other requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and if your health coverage is terminated as a result of such service (e.g., if you do not elect USERRA Continuation Coverage or your service lasts for more than 24 months), your health coverage under the Plan will be reinstated upon your return to Covered Employment. If upon your return to Covered Employment you do not initially meet the above requirements for initial or continuing eligibility, the Plan will provide you with coverage until you do meet those requirements on the basis of hours worked in the prior month. The Trustees have determined to provide this temporary coverage to eligible returning service members at Plan expense. The Trustees reserve the right to decide in the future that eligible returning service members must pay for such coverage themselves (at no more than the Plan's Extended Benefit Rates for COBRA coverage posted on the Plan's website, www.neibenefits.org, until they regain eligibility based on hours reported under the Plan's normal eligibility rules.

ELIGIBILITY FOR DEPENDENTS

When you are eligible for coverage, so are your eligible dependents. In order for your eligible dependents to have coverage, you must enroll them in the Plan. Your eligible dependents are:

- your Spouse. Your Spouse is defined as your legally married spouse, as recognized under state law, with whom you have a legally valid marriage certificate;
- your Child who is under age 26 regardless of his or her financial dependency on you, residency with you, student status, marital status or employment.
- a Child of your eligible dependent Child only if: (a) that Child was registered with the Benefits Office and was covered by the Plan as of May 1, 1989, and (b) that Child otherwise meets the definitions of "Child" below.

Eligibility for Disabled Dependents

If your eligible Child is incapable of self-support due to a physical or mental disability and remains in that condition after age 26, coverage of that Child will continue as long as you have coverage and the Child remains disabled. Proof of disability for a disabled dependent Child must be furnished to the Benefits Office within 31 days of the Child's 26th birthday.

PROVIDE PROOF TO THE BENEFITS OFFICE

Proof of disability for disabled dependents must be furnished to the Benefits Office within 31 days of the Child's 26th birthday.

The Plan's Definition of Children

The term "Child" or "Children" includes your biological children, your legally adopted children, children placed with you for adoption or stepchildren. However, you may be required to submit to the Benefits Office proof of your Marriage to a stepchild's parent. A surviving Spouse of a deceased Participant will be permitted to enroll his or her adopted Child after the Participant's death if, in the opinion of the Trustees, documentation such as court records clearly shows that the deceased Participant was seeking to adopt the Child at the time of the Participant's death.

Qualified Medical Child Support Orders

The Plan will honor Qualified Medical Child Support Orders (QMCSOs) under the law. See page 27. However, if your Child who is subject to a QMCSO is not your eligible dependent, as defined above, you may be subject to income tax on the fair market value of the coverage provided to that Child by the Plan under the terms of the QMSCO

WHEN COVERAGE ENDS

Your coverage under the Plan will end on the earliest of the following dates:

- the day your employment with an Employer in a category of work covered by the Plan terminates (unless coverage is extended as described below due to a Disability, layoff or work-stoppage due to a labor dispute, or unless you immediately retire);
- the day the Plan terminates;
- when your Employer fails to make the required contributions to the Benefits Office when due on your behalf for two or more months;
- the day your Employer stops making contributions to the Plan on your behalf because your covered employment has ended; or
- the day you stop making required self-payments.

Generally, benefits will not be paid for expenses you incur after your coverage terminates.

In certain circumstances such as retirement, disability or being temporarily laid-off, you may be able to extend your benefits coverage through the Plan by making payments.

If your coverage ends and you are not eligible to extend your coverage through the Plan, you may be able to purchase continuation coverage through COBRA, described on pages 19-23.

Eligibility upon Termination

An Employee who is terminated from employment due to substance abuse and seeks treatment for this condition within 30 days after his termination of employment will be eligible for continued mental health and substance abuse benefits under the Plan, but only through the course of treatment for his substance abuse condition. This continued coverage does not extend to any other benefits under the Plan, nor does it extend coverage to the Employee's dependents.

When Coverage Ends for Your Dependents

Coverage will end for your eligible dependents on the earliest of the following:

- when your coverage terminates.
- on the last day of the calendar month in which an individual is no longer considered an eligible dependent by the Plan's definition; e.g. divorce or Child turns 26 (see page 14 for details).
- when you or your eligible dependent ceases to make any self-payment required for coverage (including authorized pension benefit deductions).
- on the last day of the calendar month in which, in accordance with procedures established by the Trustees, you request to terminate your minor Child's dependent coverage under the Plan because you determine that more favorable alternative coverage from another plan, group health insurance, or public program is available only if that Child is not covered under this Plan. If you and your Child age 18 or over determine that more favorable alternative coverage from another plan, group health insurance or public program is available only if that Child is not covered under this Plan, both you and your Child must consent to terminate the Child's dependent coverage. A dependent Child whose coverage is terminated in this way may again obtain coverage under the Plan, if otherwise eligible, on the first day of the calendar month after the calendar month the Benefits Office receives written notice of his or her reenrollment.
- when the Plan terminates.

Coverage for Retired Employees

FAST FACTS:

- **As a Retiree, automatic deductions will be taken from your National Elevator Industry Pension Plan monthly benefit to pay the cost of health benefits. (Other payment procedures may apply to Retirees of the IUEC Officers and Employees Pension Plan and NEI Fund Office Employees Defined Benefit Pension Plan. Please contact the Benefits Office for more information.)**
- **Once you're eligible for Medicare coverage, you are required to enroll in Medicare Parts A and B. Your coverage under this Plan will become supplemental. The amount you pay for coverage under the Plan will be reduced once you have enrolled in Medicare Parts A and B.**
- **As a Retiree, you may elect medical coverage only, or medical, dental and vision coverage.**
- **Only Retirees receiving pension benefits from the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan and NEI Fund Office Employees Defined Benefit Pension Plan and who otherwise satisfy the eligibility rules below are eligible for Retiree benefits under the Plan.**

When you retire, you may continue most of your coverage by making monthly payments to the Benefits Office.

When You Retire:

- Your eligibility for weekly income benefits will terminate.
- Your life insurance and AD&D benefits will terminate (except as provided on page 63); however you may convert your life insurance to an individual policy.
- You may elect to continue your medical coverage only, or at an additional cost, medical plus dental and vision coverage. Note that medical coverage includes coverage for Prescription Drugs, hearing care benefits and mental health and substance abuse treatment benefits.

ELIGIBILITY AS A RETIREE

If you are eligible for benefits from the Plan as an Active Member at the time of your retirement under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan and if you have had at least 1,700 hours reported to the Plan in the 60 months immediately prior to retirement, you may elect coverage as a Retiree.

If you were not covered by this Plan as an Active Member immediately before you retired or fail to meet the above minimum hours requirements, you will not be eligible to elect coverage as a Retiree (however, you may be eligible for coverage under COBRA, as explained on page 19).

If you apply for and receive a Disability Pension from the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan but were not eligible for benefits under this Plan on the effective date of your Disability Pension, you nevertheless will be treated as if you were eligible for health benefits as an Active Member at the time of your retirement and therefore eligible for coverage under this Plan as a Retiree if you had at least 17,000 hours of covered employment prior to the effective date of your Disability Pension and were covered by this Plan at any time within the 12 months prior to your Social Security Disability Date. You must elect Retiree coverage within 30 days of the effective date of your Disability Pension. After that you will not be permitted to elect coverage.

DON'T MISS YOUR CHANCE!

In general, if you do not elect Retiree coverage when you first retire, you may not elect it at a later date. If your pension benefits are suspended, you will lose entitlement to your Retiree health benefits coverage and will not be able to elect it again unless your pension benefits were suspended because you returned to covered employment and were eligible for benefits under the Health Benefit Plan as an Active Member.

YOUR COVERAGE

If you elect Retiree medical coverage, you and your eligible dependents will receive medical benefits. If you elect medical coverage, you may also elect dental and vision coverage. Dental and vision coverage are provided together—you may not elect just dental or just vision coverage. If when you retire you elect medical coverage only, you cannot later elect to also receive dental and vision coverage.

Your coverage will change when you, or one of your eligible dependents, becomes eligible for Medicare Part A and B. Once you, or an eligible dependent, become eligible for Medicare Part A and B, your Retiree coverage or your eligible dependent's coverage will supplement your or your eligible dependent's Medicare coverage. Proof of coverage in Medicare Part A and B must be submitted to the Benefits Office within 90 days of the effective date of the coverage to receive the lower rate.

If you do not elect Retiree coverage when you first retire, you may not elect it at a later date. Moreover, if when you first retire you elect medical coverage only, you will not be permitted to elect dental and vision coverage at a later date. If you do not elect Retiree coverage when you retire, you may be eligible for coverage under COBRA (see pages 19-23).

Cost for Coverage

The amount you pay for Retiree coverage varies and depends on a variety of factors:

- Are you covering yourself only or yourself and your eligible dependents?
- Have you elected medical coverage only, or medical, dental and vision coverage?
- Are you an Early Retiree?
- Are you receiving a Disability Pension?
- How many hours have you worked in covered employment over your entire career and in the 60 months immediately prior to your retirement?
- What's your age and, if applicable, your Spouse's age at retirement?
- Are you eligible for Medicare?

When you apply for Retiree coverage, the Benefits Office will give you the specific monthly rate for coverage that applies to you. If your National Elevator Industry Pension Plan benefit amount is sufficient to cover the monthly cost of coverage, it will be deducted directly from your monthly pension benefit. Otherwise, you will be required to submit a payment directly to the Benefits Office. (Other payment procedures may apply to retirees of the IUEC Officers and Employees Pension Plan and NEI Fund Office Employees Defined Benefit Pension Plan. Please contact the Benefits Office for more information.)

The cost for your coverage will be the "standard rate" (or "standard monthly rate") if you meet the following requirements:

- you have at least 5,100 hours of work in covered employment in the 60 months immediately before you retire and at least 25,500 hours of work in covered employment reported to the Plan since June 30, 1962; or
- you have at least 3,400 hours of work in covered employment in the 60 months immediately before you retire and at least 42,500 hours of work in covered employment reported to the Plan since June 30, 1962.

Special standard rates apply if, on or after August 1, 2003, you retired prior to age 58. Special standard rates also apply if, after December 31, 1992, you incurred a break in coverage of 5 or more consecutive years and retired after June 30, 2003. All current standard rates are posted on the Plan's website. The Trustees adjust these rates periodically, and you will receive notice when they change.

If you do not meet the minimum hours requirements for paying the standard monthly rate, you may still be eligible to purchase Retiree coverage at an increased rate if you have at least 1,700 hours of work in covered employment reported to the Plan in the 60 months immediately before you retire. The increased rate that will apply to you will be determined by the total number of hours you worked in covered employment and the number of hours you worked in covered employment in the 60 months immediately before you retire. The chart below shows how your adjusted monthly rate will be determined. For example, if you have a total of 40,000 hours reported to the Plan with 4,000 hours reported during the 60 months prior to your retirement, your monthly cost of coverage will be the applicable standard monthly rate multiplied by a retiree factor of 1.33.

If you elect retiree coverage at the time you retire then return to covered employment and become an Active Member, and provided you notify the Benefits Office in writing within 30 days after taking a job in covered employment, the hours you work in covered employment after your initial retirement may be taken into account solely for the purpose of reducing your retiree health factor when you re-retire. However, if the hours you work in covered employment after your initial retirement would have the effect of increasing your retiree health factor, your retiree health factor based on when you first retired will be used for determining your specific monthly rate for retiree coverage at the time you re-retire.

TOTAL HOURS REPORTED TO HEALTH BENEFIT PLAN AFTER JUNE 30, 1962	HOURS DURING 60 MONTHS PRIOR TO RETIREMENT			
	6,800 AND OVER	5,100 TO 6,799	3,400 TO 5,099	1,700 TO 3,399
51,000 and over	1.00	1.00	1.00	1.11
42,500 to 50,999	1.00	1.00	1.00	1.19
34,000 to 42,499	1.00	1.00	1.33	1.36
25,500 to 33,999	1.00	1.00	1.50	1.53
17,000 to 25,499	1.60	1.63	1.67	1.70
8,500 to 16,999	1.76	1.80	1.84	1.87
Under 8,500	1.93	1.97	2.01	2.04

If you have been awarded and you are receiving a Disability Pension from the National Elevator Industry Pension Plan, the IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, you will only pay the standard rate for coverage regardless of your total reported hours or hours reported to the Plan during the 60-month period prior to your retirement.

If you are not eligible for a Disability Pension, but on account of a Disability continuously received extended benefits from this Plan from the start date of those benefits until the effective date of your pension under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, and you are receiving a Social Security Disability award for the Disability that made you eligible to receive extended benefits under this Plan, you will only pay the standard monthly rate, regardless of your total reported hours or hours reported to the Plan during the 60 months prior to retirement.

The chart on the previous page will also be applied to a deceased employee's work history to determine the cost of benefits to be paid by a surviving Spouse receiving a Pre-Retirement Spouse's Benefit from the National Elevator Industry Pension Plan (or a Preretirement Surviving Spouse Annuity under the IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan). However, if this results in the cost of benefits including dental and vision being greater than the surviving Spouse's monthly benefit, and the deceased Employee had at least 8,500 hours reported to the Plan in the 60 months prior to his or her death, the surviving Spouse will pay only the standard monthly rate.

If you are receiving a pension from the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan upon your death, the factor applied to your cost of Retiree coverage will also be applied to your surviving Spouse who is eligible under the Plan.

WHEN COVERAGE ENDS

Your Retiree coverage will end on the earliest of the following dates:

- The last day of the calendar month in which you are no longer a Retired Employee;
- The day the Plan terminates; or
- The day you stop authorization to have payments deducted from your monthly pension benefit toward the cost of your coverage or otherwise fail to make timely self-payments towards the cost of your coverage.

Once your eligibility for Retiree coverage ends, you are generally not eligible for benefits again. However, if you elected to take Retiree coverage when you first retired, then returned to covered employment and you again meet the initial eligibility requirements as an Active Member, you may purchase Retiree coverage when you retire again. To be eligible to elect coverage again, you must make your election immediately upon your retirement.

If you lose entitlement to Retiree coverage because your pension benefit under the NEI Pension Plan has been suspended because you engaged in "Disqualifying Employment" as that term is defined by the National Elevator Industry Pension Plan, you will be given 30 days to stop working in Disqualifying Employment. If you fail or refuse to stop working in Disqualifying Employment within 30 days, you will lose health coverage permanently.

Any Retiree age 65 or older but not yet age 70 1/2 who works fewer than 40 hours per month in what would otherwise be Disqualifying Employment under the NEI Pension Plan, or any Retiree over age 70 1/2 who works any hours which would be Disqualifying Employment if he was under age 70 1/2, may maintain Retiree coverage under the Plan. However, such Retiree will have to pay the full cost of the Retiree's coverage as determined by the Plan's actuary while so employed. Contributions received by the Plan from any Employer will be credited against the full cost of the Retiree's coverage. Once the Retiree ceases such employment, the cost of his Retiree coverage shall be reduced to 50% of the full cost of the applicable coverage. This rate shall remain in effect as long as the Participant remains a Retiree (but shall increase to full cost during any period of reemployment) and the 50% of applicable rate shall continue for a surviving Spouse.

Each year the Benefits Office sends certification notices to all Retirees under age 70 1/2 who are receiving pensions from the NEI Pension Plan. These notices require Retirees to report all employment engaged in while on retirement. This Plan relies on the information Retirees include in these certification notices to determine ongoing eligibility for Retiree coverage and the cost of Retiree coverage. When a Retiree reaches age 70 1/2, this Plan will send a similar notice in which the Retiree must report all employment engaged in during the prior year. Failure to respond or untruthful responses to these certification notices will result in the Retiree's coverage under this Plan being permanently terminated.

Continuing Your Coverage Under COBRA

FAST FACTS:

- **You, your Spouse and other eligible dependents may elect COBRA coverage when your NEI Health Benefit Plan coverage ends due to a Qualifying Event.**
- **To continue coverage under COBRA, you must elect COBRA coverage and make timely monthly payments to the Benefits Office.**

The Plan provides to eligible Active Members extended benefit coverage when they are disabled or laid-off from work. The Plan also provides retiree coverage to eligible Retirees of the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan and the NEI Fund Office Employees Defined Benefit Pension Plan. For more information about how you can extend your coverage in these circumstances, refer to the "Life Events" chapter, beginning on page 24.

If you're not eligible for extended coverage through the Plan when your coverage would otherwise end and you experience a "Qualifying Event," you may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

To keep your coverage under COBRA, you must make monthly payments to the Benefits Office on time. You are fully responsible for making your COBRA payments.

By making the applicable COBRA monthly payments, you, your Spouse and/or your dependents may continue the medical, dental, and vision coverage that you had prior to the date you would have otherwise lost coverage under the Plan. Under COBRA, your coverage can last for up to 18, 29 or 36 months, depending on the Qualifying Event.

QUALIFYING EVENTS

To be eligible for COBRA Continuation Coverage, you (as the member), your Spouse and/or your dependent(s) must lose coverage due to any one of the following Qualifying Events:

QUALIFYING EVENT	WHO MAY PURCHASE CONTINUATION COVERAGE	MAXIMUM PERIOD OF COVERAGE
Member loses eligibility due to termination or a reduction in hours of employment (including retirement)	Member, Spouse and/or dependent Children	18 months
Termination or reduction in hours while you or your dependent is disabled	Member, Spouse and/or dependent Children	29 months (18 months plus an additional 11)
Member becomes entitled to Medicare and voluntarily drops Plan coverage	Spouse and/or dependent Children	36 months
Member dies	Spouse and/or dependent Children	36 months
Member is divorced or legally separated from Spouse	Spouse and/or dependent Children	36 months
Child is no longer considered a dependent child under the Plan's definition	Dependent Child	36 months

If a member loses eligibility because he is terminated due to gross misconduct, COBRA Continuation Coverage is not permitted, since that is not a Qualifying Event.

QUALIFIED BENEFICIARIES

Under the law, only "qualified beneficiaries" are entitled to COBRA Continuation Coverage. Qualified beneficiaries are:

- you, as the member;
- your Spouse; and
- your dependent Child.

A Child who becomes a dependent child by birth, adoption or placement for adoption with you (but not a Spouse who becomes your Spouse) during a period of COBRA Continuation Coverage is also a qualified beneficiary under COBRA. You must enroll your Child within 31 days of the date of the birth, adoption or placement for adoption.

One or more of your family members may elect COBRA even if you do not. However, in order to elect COBRA Continuation Coverage, the members of your family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent Children living with him or her.

HOW TO ELECT COBRA CONTINUATION COVERAGE

NOTIFY THE BENEFITS OFFICE

You or a family member should notify the Benefits Office when any Qualifying Event occurs to avoid confusion over the status of your health care in case your Employer does not provide prompt or correct information.

In order to elect COBRA Continuation Coverage, the Benefits Office must be notified in writing when you experience a Qualifying Event. You (or your Employer) must notify the Benefits Office in writing within 60 days from the date that the Qualifying Event occurs, or the date that you lost coverage under the Plan because of the Qualifying Event, whichever is later:

The NEI Health Benefit Plan
19 Campus Blvd, Suite 200
Newtown Square, PA 19073

In some cases, your Employer will notify the Benefits Office. In other cases, you, your Spouse or your dependent must notify the Benefits Office, as shown in the chart below.

YOUR EMPLOYER Your Employer must notify the Benefits Office of your:	YOU You, your Spouse (or your dependent) must notify the Benefits Office of your:
■ termination of employment	■ divorce
■ reduction in hours	■ legal separation
	■ Child losing dependent status under the plan
	■ entitlement to Medicare
	■ retirement
	■ death
	■ ceasing to be eligible for extended benefits for laid-off Employees because of any reason other than failure to submit timely extended benefit payments

When the Benefits Office receives notice of the Qualifying Event, it will mail you an election form, information about COBRA and the date on which your coverage will end if you do not elect COBRA Continuation Coverage. Under the law, you, your Spouse and/or your eligible dependents have 60 days to elect COBRA Continuation Coverage from the later of the date:

- you would have lost coverage because of the Qualifying Event; or
- you and/or your eligible dependents received the election form and COBRA information.

If you, your Spouse and/or any of your eligible dependents do not elect COBRA Continuation Coverage within 60 days of the Qualifying Event (or, if later, within 60 days after receiving the COBRA election form), you, your Spouse and/or your eligible dependents will not have any group health coverage from this Plan after your coverage would otherwise end.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Benefits Office informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send the Benefits Office.

PAYING FOR COBRA CONTINUATION COVERAGE

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your dependents become eligible for this coverage, the Benefits Office will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be up to 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Continuation Coverage for Disabled Participants.")

You must make payments so that your COBRA coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA payment to the Benefits Office within 45 days from the date on which you or your dependent mail the COBRA election form back to the Benefits Office, as determined by postage cancellation. Payments for subsequent months are due on the first day of the month for which coverage is provided. A payment will be considered to have been made on the first day of a month as long as the payment is received within a 30-day grace period.

If you choose COBRA Continuation Coverage within the election period but after the date your Plan eligibility ended, you must pay the required COBRA premiums retroactively to cover the elapsed period.

What You Need To Do:

If you lose coverage due to a Qualifying Event:

- Inform the Benefits Office of the Qualifying Event and request a COBRA election form.
- Complete and mail back the election form within 60 days of the date you received it, or 60 days of the date the Qualifying Event occurred, whichever is later.
- Make your first payment to the Benefits Office within 45 days from the date on which you mail your COBRA election form back to the Benefits Office.

COBRA CONTINUATION COVERAGE FOR DISABLED PARTICIPANTS

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or your Spouse or dependent) become disabled, you and your Spouse and dependents may be eligible to continue your COBRA coverage for an additional 11 months for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your Spouse or dependent) are disabled and therefore entitled to Social Security disability income benefits. You (or your Spouse or dependent) must notify the Benefits Office of the Social Security determination of disability within 60 days from the date you received the determination.

If you are eligible for the 11-month extension, your COBRA premiums may be up to 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- the last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- the end of the 29 months of COBRA coverage;
- the date the disabled person becomes entitled to Medicare.

NEED TO CONTACT THE SOCIAL SECURITY ADMINISTRATION?

Visit the Social Security Administration website at www.ssa.gov, or call 1-800-772-1213.

If you recover from your disability before the end of the initial 18 months of COBRA coverage, you will not have the right to purchase extended coverage. You must notify the Benefits Office within 30 days of:

- the date that you receive a final Social Security determination that you, your Spouse and/or your dependent(s) are no longer disabled; or
- the date that the disabled person becomes entitled to Medicare.

MULTIPLE QUALIFYING EVENTS WHILE COVERED UNDER COBRA

The maximum period of COBRA coverage is 36 months, even if you, your Spouse or a dependent experience another Qualifying Event while you're already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected Spouse or dependent may extend coverage for another 18 months if:

- you get divorced or legally separated;
- you become entitled to Medicare;
- your Child is no longer a dependent under the Plan's definition; or
- you die.

For Example:
John stops working (the first COBRA-Qualifying Event), and enrolls himself and his family in COBRA Continuation Coverage for 18 months. Three months after his COBRA coverage begins, John's Child turns 26 and no longer qualifies as a dependent Child under the Plan's definition. John's Child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

You, as the member, are not entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

Coverage for your Dependents if You're Enrolled in Medicare

If you are enrolled in Medicare and your hours are reduced or your employment is terminated, your eligible dependents would be entitled to COBRA coverage for a period of 18 months (29 months if the 11-month Social Security Disability extension applies) from the date of your termination of employment or reduction in hours or 36 months from the date you became entitled to Medicare, whichever is longer.

SPECIAL COBRA ENROLLMENT RIGHTS

If you marry, have a newborn Child, adopt a Child or have a Child placed with you for adoption while you are enrolled in COBRA, you may enroll that Spouse or Child for coverage for the balance of the period of COBRA coverage. You must enroll your new dependent within 31 days of the Marriage, birth, adoption or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your Spouse or dependent Child loses coverage under another group health plan, within 31 days after the termination of the other coverage you may enroll that Spouse or Child for COBRA Continuation Coverage for the balance of the period of COBRA coverage.

To be eligible for this special enrollment right, your Spouse or dependent Child must have been eligible for coverage under the terms of the Plan but declined coverage when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage.

Adding a Spouse or dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. COBRA rates, along with other extended benefit rates, are posted on the Plan's website. The Trustees may adjust these rates annually, and you will receive notice when they change.

CONFIRMATION OF COVERAGE TO HEALTH CARE PROVIDERS

Under certain circumstances, federal rules require the Plan to inform your Physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the Physician or provider is requesting confirmation of coverage and you are eligible for (but you have not yet elected) COBRA Continuation Coverage, or you have elected COBRA Continuation Coverage but have not yet paid for it.

TERMINATION OF COBRA COVERAGE

COBRA coverage will terminate on the last day of the maximum period of COBRA coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes covered by another group health plan that does not contain any legally applicable exclusion or limitation with respect to preexisting conditions that the Covered Individual may have;
- The person receiving the coverage becomes entitled to Medicare;
- The Plan terminates and no longer provides group health coverage to any members; or
- The Employer that you worked for before the Qualifying Event has stopped contributing to the Plan; and
    - The Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered under this Plan; or
    - The Employer starts contributing to another multiemployer plan that is a group health plan.

If you have questions about COBRA Continuation Coverage, contact the Benefits Office at 1-800-523-4702.

Life Events That Affect Your Coverage

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when you experience certain "life events" and what you must do to make sure you get the most from your coverage.

FAST FACTS:

- **You should notify the Benefits Office as soon as possible if you experience a life event that may affect your coverage.**

The following life events may affect your coverage:

- Moving to a new address
- Losing eligibility (dependents)
- Getting married or divorced
- Being laid-off
- Having a baby or adopting a Child
- Termination of your employment with an Employer
- Ceasing or reducing hours of covered employment
- Becoming disabled
- Retiring
- Taking Family Medical Leave
- Becoming eligible for Medicare
- Entering active military service
- Death

IF YOU MOVE

If you move, keep in touch! Complete the Enrollment Form address section and send it to the Benefits Office as soon as possible to make sure your records are up to date and to avoid a delay in the payment of your claims.

IF YOU GET MARRIED

If you are covered under the Plan and you legally marry, your Spouse is eligible for dependent benefits. The word "Marriage" means only a legal union between two persons recognized under the laws of a state in the United States as married with a legally valid marriage certificate. You must enroll your Spouse by providing the Benefits Office with a completed notarized enrollment form, and copies of your marriage certificate and Spouse’s birth certificate. Domestic partners are not covered by the Plan.

What You Need To Do:

If you get married, you should provide the Benefits Office with the following information within six months of your Marriage:

- A completed, notarized enrollment form;
- A copy of your marriage certificate;
- A copy of your Spouse's birth certificate; and
- A copy of your Spouse's medical insurance information, if he or she is covered under another group health plan.

Once you provide the required information, your Spouse is eligible for coverage under the Plan as of the date of your Marriage. If you wish to name your Spouse as your beneficiary for your life insurance benefit or accidental death and dismemberment benefit, contact the Benefits Office. You will be required to change your beneficiary with a completed, notarized enrollment form. To be effective, your updated enrollment form must be on file with the Benefits Office at the time of your death.

If your Spouse is covered under another group health plan, you must report this other coverage to the Benefits Office. The amount of benefits payable under the Plan will be coordinated with your Spouse's other coverage. Benefits for your Spouse under the Plan will be paid after any benefits are payable from your Spouse's plan. For more information, see "Coordination of Benefits" on page 69.

IF YOU ACQUIRE A STEPCHILD THROUGH MARRIAGE

Your stepchild may be eligible for coverage under the Plan. Notify the Benefits Office if you are planning to have a stepchild covered under this Plan. You will need to provide the Benefits Office the following information:

- A completed Enrollment Form adding the stepchild;
- A copy of your divorce decree or custody orders for the stepchild;
- Your stepchild's birth certificate;
- A copy of your marriage certificate; and
- A copy of your stepchild's other health plan information, if he or she is covered under another group health plan.

IF YOU HAVE A BABY

Once your Child is born, notify the Benefits Office to have your Child covered under the Plan. As long as you are eligible for benefits, your Child will be covered as of the date of his or her birth.

What You Need To Do:

If you have a baby, you should provide the Benefits Office with the following information within six months of your Child's birth:

- A completed Enrollment Form adding your Child as a dependent;
- A copy of your baby's birth certificate; and
- A copy of your baby's other health plan information if he or she is covered under another group health plan or program.

The Plan covers expenses related to maternity and Child wellness (see page 40).

IF YOU ADOPT A CHILD OR BEGIN ADOPTION PROCEEDINGS

If you adopt a Child or begin adoption proceedings, contact the Benefits Office. Your Child will be covered as of the effective date the Child is placed with you for adoption as long as you are responsible for health care coverage and your Child meets the Plan's definition of an eligible dependent.

What You Need To Do:

If you need to add an adopted Child to your coverage, you should provide the Benefits Office with the following information within six months of the adoption or placement for adoption:

- A completed Enrollment Form adding your Child as a dependent;
- A copy of the adoption certificate or documentation of the start of adoption proceedings; and
- A copy of your Child's other health plan information if he or she is covered under another group health plan or program.

IF YOU TAKE FMLA LEAVE

Family Medical Leave Act (FMLA)

You and your eligible dependents will be covered under the Plan if you are entitled to—and take—leave under the Family Medical Leave Act (FMLA) as long as contributions are continued by your Employer during your leave. Under FMLA, you have the right to take up to 12 weeks of unpaid leave for your serious Illness, after the birth, adoption, or placement of a Child with you for adoption, or to care for your seriously ill Spouse, parent or child without losing your coverage.

The FMLA requires your Employer covered by the FMLA to continue to make contributions to the Plan while you are on FMLA leave.

During your leave, you and your eligible dependents can continue your medical coverage and other benefits offered through the Plan. You are generally eligible for leave under FMLA if you:

- have worked for a covered Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 Employees live within 75 miles of the work location.

You will continue to be eligible for benefits until the end of your FMLA leave, provided that the contributing Employer that grants your FMLA leave provides the required notification and payment to the Plan required by this law. Call your Employer to determine whether you are eligible for FMLA leave.

IF YOUR CHILD'S ELIGIBILITY FOR BENEFITS CHANGES

If for any reason your Child no longer meets the Plan's dependent eligibility requirements, you must notify the Benefits Office in writing immediately. Your failure to provide such notice, and the submission of claims while your dependent is no longer eligible for coverage, will be considered an intentional misstatement of material fact and/or fraud. If you do not notify the Benefits Office, you and your Child will be jointly responsible for reimbursing the Plan for all charges that were paid by the Plan on behalf of your Child while he or she was not eligible for coverage.

When Your Child Turns 26

Your dependent Children are covered under this Plan until they turn 26. Generally, your Child's eligibility under the Plan will stop at age 26 (but see "Eligibility for Disabled Dependents, page 14). Your Child's loss of eligibility at age 26 is a Qualifying Event (see page 19), and your Child may enroll in COBRA Continuation Coverage at that time.

IF YOU DIVORCE

If you divorce from your Spouse, notify the Benefits Office immediately. Once you divorce, your Spouse is no longer eligible for benefits under this Plan, however, he or she may enroll in COBRA Continuation Coverage (see page 19). **Your divorce automatically revokes your Spouse as your designated beneficiary for all Plan purposes (such as the Plan's life insurance or accidental death and dismemberment benefits) and you must designate a new beneficiary (or redesignate your former Spouse, if you so desire) by submitting to the Benefits Office a completed, notarized enrollment form.**

If you do not notify the Benefits Office when you divorce, you will be responsible for reimbursing the Plan for all charges that were paid by the Plan on behalf of your former Spouse while he or she was not eligible for coverage.

What You Need To Do:

- Contact the Benefits Office or visit www.neibenefits.org to obtain an Enrollment Form. As soon as your divorce becomes final, submit to the Benefits Office your updated Enrollment Form designating your new beneficiary (or redesignate your former Spouse, if you so desire);
- Provide the Benefits Office with a copy of your divorce decree;
- Provide the Benefits Office with a copy of any Qualified Domestic Relations Order (QDRO); and
- If you have Children and you do not have custody, provide the Benefits Office with a copy of any Qualified Medical Child Support Order (QMCSO), if applicable.

If your former Spouse wants to purchase COBRA Continuation Coverage, he or she must contact the Benefits Office. Your former Spouse may purchase COBRA and receive COBRA Coverage for up to a maximum of 36 months as long as the Benefits Office is informed of the divorce within 60 days of the day the divorce becomes final. For more information, see page 19.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a court order, judgment or decree that recognizes that an alternative recipient may be entitled to benefits under this Plan in the event of a divorce or other family law action. The Plan will honor all QMCSOs.

Orders must be submitted to the Benefits Office so that the Benefits Office can determine whether the order is a QMCSO under federal law. As required under the ERISA, this Plan will recognize a QMCSO that:

- provides for health coverage to the Child(ren) under state domestic relations law (including a community property law); and
- relates to benefits under this Plan.

Participants and beneficiaries may receive from the Benefits Office, upon request and free of charge, a copy of the Plan's procedures governing QMCSO determinations.

Please contact the Benefits Office at 1-800-523-4702 if your situation involves a QMCSO for information about how these orders are handled. You and/or your and beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedures from the Benefits Office.

However, if your Child who is the subject of the QMCSO is not your "eligible dependent" as defined above (see page 14), you may be subject to income tax on the fair market value of the coverage provided to that Child by the Plan under the terms of the QMCSO.

IF YOU ENTER ACTIVE MILITARY SERVICE

If you leave employment with a participating Employer to serve in the U.S. Armed Forces or the National Guard (under federal authority) for 30 or fewer days, and you meet the other requirements of the USERRA, you (and your Spouse and/or eligible dependent(s)) will continue to receive health care coverage under this Plan for up to 30 days at no cost to you. The amount of Employer contributions that would otherwise be owed for the period of your military service will be considered an administrative expense of the Plan, and no individual Employer will be required to make such contributions.

If your active duty lasts for 31 days or longer, you (and your Spouse and/or your eligible dependent(s)) will be eligible for continuation coverage under the Plan during your service, pursuant to USERRA. The Trustees have determined to provide this continuation coverage to eligible Participants in the uniformed services at Plan expense. The Trustees reserve the right to decide in the future that eligible Participants in the uniformed services must pay for such coverage themselves (at no more than the Plan's extended benefit rates for COBRA coverage on the Plan's website www.neibenefits.org). Contact the Benefits Office at 1-800-523-4702 for information if you are called to active military service.

USERRA continuation coverage is governed by the same procedures as are described beginning on page 19 for COBRA except for the following:

Duration of Coverage. USERRA continuation coverage will be provided for the lesser of (i) 24 months from the date on which your qualified leave for military service begins or (ii) the period beginning on the date your qualified leave for military service begins and ending on the date you fail to apply for reemployment within the time frames proscribed by USERRA.

Using Run-Out Eligibility. If you elect USERRA Continuation Coverage and have sufficient hours of credited employment to provide eligibility for all or a portion of the period of your military service, your existing eligibility will be frozen until you return to covered employment from military service so that you may use it to establish your eligibility for coverage during a later period of unemployment. (The Trustees reserve the right to decide in the future that eligible Participants in the uniformed services must pay for continuation coverage. Should that occur, you will have the option to elect to use any existing period of eligibility during your period of military service in lieu of paying for continuation coverage.)

Notice and Election of Coverage. You are required by USERRA to give advance notice to your Employer that you are leaving for a period of military service, unless giving such notice is impossible or unreasonable or barred by the military. Upon giving such notice to your Employer, you should also notify the Benefits Office in writing that you are leaving to perform military service and that you elect to continue your medical coverage. Within 60 days after receipt of that notice, the Benefits Office will provide you with specific information regarding the cost of USERRA continuation coverage.

If you do not give advance notice of your leaving for military service to your Employer, your coverage under the Plan will terminate as of the date you leave employment for military service. If your failure to give advance notice of your military service is excused, because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Benefits Office will reinstate your health coverage retroactive to the date you left employment if you contact the Benefits Office to request continuation coverage within 30 days of your leaving employment and return the USERRA Continuation Coverage election form to the Benefits Office with your initial payment (if any) within 30 days of receiving that form.

If you give advance notice of your leaving for military service to your Employer but fail to notify the Plan that you desire to elect continuation coverage, your coverage will be terminated as of the date you leave employment for military service. The Benefits Office will reinstate your health coverage retroactive to the date you left employment, however, if you contact the Plan to request continuation coverage within 30 days of your leaving employment and return the USERRA Continuation Coverage election form to the Benefits Office with your initial payment (if any) within 30 days of receiving that form.

If you are called to active military service, do not hesitate to contact the Benefits Office at 1-800-523-4702 for help in understanding your rights to coverage under the Plan.

IF YOU ARE LAID-OFF

If you are temporarily laid-off due to lack of work and continue to satisfy the eligibility requirements for extended benefits as a laid-off Employee, you may retain your coverage for free for up to two calendar months following the month in which your earned coverage ended under the 80/160/300 Rolling Hours Rule Test (explained on page 12). After that, if you are otherwise eligible, you may continue your coverage by making monthly payments directly to the Benefits Office. See "Extended Benefit Rates" posted at the Plan's website www.neibenefits.org.

What You Need To Do:

- If you are laid-off, you must contact your Local Union office.
- Your Local Union office will contact the Benefits Office.
- You must mail your monthly extended benefit payments to the Benefits Office by the 20th of the month prior to the month for which you want coverage.

Eligibility

In general, to be eligible to purchase "laid-off" benefits, you must:

- have worked in covered employment for at least 600 hours (including probationary hours) in the 18 months before your lay-off;
- be available for work in covered employment (and accept work, when it's offered);
- regularly contact your Local Union Business Representative for work opportunities;
- be registered on your Local Union's out-of-work list.

You are not eligible to purchase laid-off benefits if you:

- were not working in the elevator industry on a regular basis and you do not meet the 80/160/300 Rolling Hours Rule Test;
- are working outside the elevator industry;
- have left the elevator industry;
- are not considered available for work; or
- quit your job or are terminated.

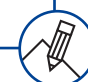
YOU ARE RESPONSIBLE FOR NOTIFYING THE PLAN IF YOU ARE NO LONGER AVAILABLE FOR WORK IN COVERED EMPLOYMENT. If you do not notify the Benefits Office when you are no longer available for work or otherwise cease to be eligible for extended benefits as a laid-off Employee, you will be responsible for reimbursing the Plan for all charges that were paid by the Plan on behalf of you, your Spouse and/or your other dependents while you were not eligible for extended benefits.

If you are laid-off, you will only be eligible for two free months of coverage once per lay-off and only once in any 12-month period. An unused free month of coverage during a 12-month period can be used at any time during that period. Once extended benefit coverage is voluntarily terminated or changed it may not be reinstated at a later date. However, coverage may be reinstated if you return to work and meet the Rolling Hours Test. If you become laid-off, rehired, then laid-off again within 12 months of your rehire, your current period of lay-off is considered a continuation of the prior period(s) of lay-off.

The Plan will send you a monthly billing statement. In order to ensure continued eligibility, the Benefits Office must receive your payment no later than the 20th of the month prior to the coverage month. For example, the Benefits Office must receive payment for February's coverage by January 20th.

Submit payments payable to the NEI Health Benefit Plan to: NEI Health Benefit Plan
19 Campus Boulevard, Suite 200
Newtown Square, PA 19073

> **IT'S A PACKAGE DEAL**
>
> *You may choose to pay for just medical coverage, or medical coverage plus dental/vision coverage. You must elect medical to get dental and vision.*



IF YOU STOP WORKING

If you stop working, your coverage under this Plan will end on the day your employment ends. If your coverage ends due to your termination or a reduction in hours below the minimum hours required to maintain eligibility under the Rolling Hours Rule, you may elect to purchase COBRA Continuation Coverage for yourself and your family for up to 18 months. You must inform the Benefits Office within 60 days after the later of the date of your reduction in hours or termination of employment or the date of loss of coverage or you will lose your right to elect COBRA Continuation Coverage.

> **What You Need To Do:**
>
> If you stop working, you should:
> - Inform the Benefits Office; and
> - Enroll in COBRA, if you wish to continue your coverage under this Plan.

Converting Your Life Insurance

If you leave covered employment, the Benefits Office will send you notice of your right to transfer your group life insurance to a policy through Amalgamated Life Insurance Company (Amalgamated). To convert your insurance, you must apply to Amalgamated within 31 days after your life insurance terminates or 15 days after you receive notice of your right to convert from the Benefits Office, whichever is later. You must make the applicable premium payments to keep your new coverage in force.

If There is a Work Stoppage Due to a Labor Dispute

If you are unemployed because of a work stoppage due to a labor dispute, your coverage will continue until the last day of the month following the month the work stoppage began. After that, you may continue your coverage by making monthly payments to the Benefits Office. For information about rates and eligibility, contact the Benefits Office.

> **RETURNING TO WORK**
>
> *If you maintain your eligibility while you are laid-off or Disabled, for the month of rehire and the month that follows, the Rolling Hours Test will apply to the three months just before the month of your most recent Disability or layoff. In your third month of reemployment, the Rolling Hours Test will apply to the rehire month plus the two months just before the month of your most recent Disability or layoff. Contact the Benefits Office for more information.*

IF YOU BECOME DISABLED

If you become Disabled, your coverage will be continued until the earlier of:

- the last day of the month in which your Disability ceases; or
- unless you are eligible for and make required contributions for extended benefits (see below), the last day of the sixth month following the month in which your earned coverage ended under the 80/160/300 Rolling Hours Rule Test. While on Disability status, you are eligible for up to six free months of coverage per Disability absence and only once in a 12-month period.

After that, you may continue your coverage by applying for extended benefits and making payments to the Benefits Office. Once extended benefit coverage is voluntarily terminated or changed it may not be reinstated at a later date. However, coverage may be reinstated if you return to work and meet the Rolling Hours Test.

WHAT DOES THE PLAN MEAN BY "DISABILITY OR DISABLED?"

For purposes of receiving extended benefits on account of "Disability," the Plan defines the first two years of Disability as the complete inability to perform the regular duties of an elevator constructor, mechanic, apprentice or helper. After two years, Disability means the inability to perform the duties of any gainful employment for which you are qualified by training, education or experience.

If You are Receiving a Disability Pension

If you are receiving a Disability Pension from the National Elevator Industry Pension Plan, the IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, you may be eligible for Retiree coverage (see page 16). To be covered under this Plan as a Retiree, monthly payments are subtracted from the monthly pension benefit you are receiving from the National Elevator Industry Pension Plan at the standard rate for coverage. Other payment procedures apply to Retirees of the IUEC Officers and Employees Pension Plan and the NEI Fund Office Employees Defined Benefit Pension Plan. For information about rates and eligibility, contact the Benefits Office; the standard rates are also posted on the Plan's website www.neibenefits.org.

If You are Not Receiving a Disability Pension

If you lose eligibility for benefits due to Disability and you do not receive a Disability Pension from the NEI Pension Plan, the IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, you may continue your benefits (other than weekly income benefits) while you remain Disabled by making monthly payments to the Benefits Office.

What You Need To Do:

If you believe you have become Disabled and you are not eligible for a Disability Pension, you should:

- Inform the Benefits Office; and
- Apply for extended benefits; or
- If you do not meet the requirements for extended benefits but wish to have your coverage under this Plan temporarily continue, elect COBRA Continuation Coverage (see pages 19 - 23).

After the first 12 months of your Disability, the Trustees will require proof of your continued Disability on at least an annual basis. They may also require you to undergo a physical exam at the Plan's expense, by a doctor selected by the Trustees. Unless you submitted proof of permanent Disability as determined by the Benefits Office, you should submit proof of your continued Disability at least once every 12 months. In addition, once benefits are extended on a self-pay Disability basis, the basis for extended benefits cannot be changed.

IF YOU RETIRE

Generally, when you retire, you will no longer be eligible for weekly income benefits, life insurance benefits or AD&D benefits. However, you may convert your life insurance to an individual life insurance policy. If you are receiving a Disability Pension from the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan, maintain your eligibility under this Plan as a Retiree and you are under age 65, you will continue to receive life insurance and AD&D benefits. See page 65 for information.

What You Need To Do:

When you are ready to retire, you should:

- Inform the Benefits Office;
- Request a pension application within 180 days of your expected retirement; or
- If you are not eligible for Retiree coverage under the Plan but wish to have your coverage under this Plan temporarily continue, elect COBRA Continuation Coverage (see pages 19 - 23).

When you are ready to retire, you should contact the Benefits Office. If you were eligible for coverage under the Plan immediately before you retired, you may be eligible to continue your medical coverage by purchasing Retiree coverage. You must be receiving a pension from the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan and you must have worked at least 5,100 hours in covered employment in the 60 months immediately before you retired and at least 25,500 hours of covered employment after June 30, 1962, to purchase Retiree coverage at the "standard monthly rate".

If you do not meet the hours requirements described above, you can purchase coverage at a higher monthly rate if you have worked at least 1,700 hours in covered employment in the 60 months immediately before you retired (see pages 16 - 18). If you do not meet the hours requirement, you still may be able to extend your coverage for as many as 18 months by purchasing COBRA Continuation Coverage.

Retiree Coverage

Retiree coverage includes medical coverage. You may also elect to continue dental and vision coverage under the Plan by paying an additional amount. You cannot purchase dental and vision coverage without purchasing medical coverage. You cannot purchase dental and vision coverage separately—if you get one, you get both. Also, if you choose not to continue dental and vision coverage at the time you first elect Retiree coverage, you will not be permitted to purchase dental and vision coverage at a later date.

If you receive a pension from the National Elevator Industry Pension Plan, the monthly payments necessary to maintain your Retiree coverage are subtracted from your monthly pension benefit. Other payment procedures apply to Retirees of the IUEC Officers and Employees Pension Plan and Retirees of the NEI Fund Office Employees Defined Benefit Pension Plan.

IF YOU DO NOT ELECT RETIREE COVERAGE AT THE TIME YOU RETIRE, YOU MAY NOT ELECT IT AT A LATER DATE. NOR MAY YOU ELECT TO RECEIVE DENTAL AND VISION COVERAGE AT A LATER DATE IF YOU CHOOSE NOT TO ELECT DENTAL AND VISION COVERAGE AT THE TIME YOU RETIRE. If you are not eligible for Retiree coverage, you may elect COBRA Continuation Coverage for up to 18 months. See page 19 for information.

IF YOU BECOME ELIGIBLE FOR MEDICARE

If you, your covered Spouse, or dependents become eligible for Social Security Retirement benefits at age 65 (or earlier if due to End Stage Renal Disease or disability), you are also eligible for Medicare. Medicare is the federally sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B).

You and/or your Spouse or other eligible dependents are required to enroll in Medicare Parts A and B as soon as you are eligible—three months before your 65th birthday, or in certain cases earlier (i.e., in the event of End-Stage Renal Disease or disability)—in order to avoid a gap in coverage. If you leave employment and have not applied for Medicare Part B within three months from the date you turn 65, it may cost you more to enroll in Part B coverage.

Your Retiree coverage under this Plan is designed to supplement the coverage you get through Medicare once you and/or your eligible dependents first become eligible to enroll in Medicare. Accordingly, your monthly costs for Retiree coverage will be reduced when you first become eligible to enroll in Medicare. For information on how your benefits are coordinated when you are eligible to enroll in Medicare Part A and Medicare Part B, see pages 16 and 70.

TO ENROLL IN MEDICARE:

- *Visit your local Social Security Office;*
- *Call 1-800-MEDICARE (1-800-633-4227); or*
- *Go to the Medicare website at www.medicare.gov.*

IF YOU DIE

If you are married and you die while you're covered by the Plan as an Active Member or Retiree, your surviving Spouse may elect to continue medical, dental and vision coverage if he or she is eligible for a surviving Spouse benefit under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan. This coverage includes your other eligible dependents covered by the Plan at the time of your death. Your surviving Spouse must file a written agreement to pay the required amount for this coverage.

Coverage for your Spouse and dependent Children will continue (while they remain eligible) until the end of the calendar month in which your Spouse dies or remarries, whichever occurs first.

If your Spouse remarries, he or she will no longer be eligible for coverage under the Plan but may extend eligibility under the Plan for as many as 36 months by electing COBRA Continuation Coverage. However, if your children are eligible dependents at the time of your death, your children under age 26 may be able to continue their coverage after your surviving Spouse remarries by making payments in the required amounts to the Benefits Office.

What Your Spouse Needs To Do to Extend Coverage Under The Plan after Your Death:

In the event of your death, your surviving Spouse must:

- Notify the Benefits Office;
- Provide the Benefits Office with a copy of your death certificate;
- Apply for your life insurance benefit (and AD&D benefit, if applicable); and
- If your Spouse is eligible for surviving Spouse benefits under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, enroll in extended coverage under the Plan by filing an agreement with the Benefits Office.

How Your Medical Plan Works

The Plan's Trustees want you and your family to be protected from high costs that are often associated with Illness or injury. That's why the Trustees have selected the Blue Cross Blue Shield BlueCard PPO as the Plan's Preferred Provider Organization (PPO) network to provide your comprehensive medical benefits.

FAST FACTS:

- **Blue Cross Blue Shield BlueCard PPO offers an extensive network of medical providers for members and cost savings through a Preferred Provider Organization (PPO).**

The Plan gives you the freedom to visit any provider you'd like. When you visit a provider in the Blue Cross Blue Shield BlueCard Preferred Provider Organization (PPO) network, your covered medical expenses are generally paid at 100% of the provider's discounted or negotiated charge after you've met the applicable deductible.

When you visit a provider that is not in the Blue Cross Blue Shield BlueCard PPO network (an "out-of-network" provider), your covered medical expenses are generally paid at 75% of the UCR Rate. The Plan's definition of UCR Rate is set forth in the Glossary of Terms in the back of this Summary Plan Description.

PAYING FOR YOUR MEDICAL EXPENSES

The Plan shares the cost of your covered medical expenses with you. You are responsible for paying:
- your annual deductible;
- Copayments, if applicable;
- your coinsurance; and
- the amount that an out-of-network provider charges that is more than the UCR Rate.

Your Annual Deductible

Your annual deductible is the amount that you must pay each year toward your covered medical expenses before the Plan will begin to pay benefits. For medical expenses, your annual deductible is $300 per person or $600 per family.

Note that if you are eligible for Medicare so that the Plan only provides supplemental coverage, you do not have to meet an annual deductible before the Plan will supplement your Medicare benefits.

Copayments

Some services, such as Emergency Room visits, require a flat fee from you—called a Copayment. You make your Copayment, if applicable, at the time you receive services.

Your Coinsurance

You do not need to pay coinsurance for most medical expenses when you use a Blue Cross Blue Shield BlueCard PPO provider for your medical care. The Plan pays for most Covered Expenses at 100% of the Blue Cross Blue Shield BlueCard PPO contracted rate, after you've met your annual deductible.

If you visit an out-of-network provider, your medical expenses are generally covered at 75% of the UCR Rate. Your coinsurance is 25% of the UCR Rate. If you are "out-of-area" and you visit an out-of-network provider, your expenses are covered at 100% of the UCR Rate.

Paying the Balance

You are responsible for paying the balance—the difference between what your provider charges and what the Plan pays—whenever you visit a provider that does not participate in the Blue Cross Blue Shield BlueCard PPO network. This is called “balance billing.”

IN-NETWORK VS. OUT-OF-NETWORK

In-Network (PPO Providers)

The Plan contracts with Blue Cross Blue Shield BlueCard PPO providers. When you visit a provider in the BlueCard Preferred Provider Organization (PPO) network, the provider accepts a contracted rate as payment in full.

Out-of-Network

You have the option of visiting any provider you'd like. If you visit a provider that is not in the PPO network (an out-of-network provider), the Plan will pay for most Covered Expenses at 75% of the provider's charge, up to the UCR Rate. You are responsible for paying your 25% coinsurance, as well as any amount that your provider charges that is more than the UCR Rate.

For Example:
The chart below shows the difference in how benefits are paid based on whether you visit a provider in the PPO network or an out-of-network provider.

	BLUE CROSS BLUE SHIELD BLUECARD PPO PROVIDER	OUT-OF-NETWORK PROVIDER
Provider's Charge	$400	$450
UCR Rate	N/A	$420
Blue Cross Blue Shield BlueCard Contracted Rate	$250	N/A
Plan Pays (after deductible, if applicable)	100% of the contracted rate—$250	75% of the UCR Rate—$315
Your Coinsurance	$0	25% of the UCR Rate—$105
Balance Billing	$0	$30 (the difference between the out-of-network provider's charge and the UCR Rate)
Your Total Cost	$0	$135 ($105 + $30)

Benefits for Out-of-Area Members

If you are considered "out-of-area" and you visit a non-PPO provider, your expenses are paid at 100% of the UCR Rate, but if your non-PPO provider charges you an amount in excess of the UCR Rate, you will be responsible for paying the amount of the charge that exceeds the UCR Rate in addition to any coinsurance that applies.

WHAT IS "BALANCE BILLING?"

Balance billing is the amount you must pay if your out-of-network provider charges more than the UCR Rate for a particular service.

For example, if the provider charges $200, but the UCR Rate is $185, you are responsible for paying the $15 difference in addition to your coinsurance, if applicable.

YOUR OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you'll pay in the calendar year for covered medical, mental health and substance abuse services. These out-of-pocket costs include your annual deductible and coinsurance amounts. There are charges that are not taken into account for determining whether you have reached your out-of-pocket maximum. These charges include:

- charges for which you are balance billed (because your out-of-network provider has charged more than the UCR Rate),
- Copayments, and
- coinsurance that is applied to Chiropractic services.

If you reach your out-of-pocket maximum, the Plan will pay 100% of your covered medical, mental health and substance abuse services expenses for the remainder of the calendar year. You should keep in mind, however, that if you reach your out-of-pocket maximum and you visit an out-of-network provider, the Plan will not cover amounts in excess of the UCR Rate, so you may be balance billed for any amount that exceeds the UCR Rate; moreover, you will continue to be responsible for any Copayments or coinsurance applied to Chiropractic services.

OUT-OF-POCKET MAXIMUMS

IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
$300 per person	$1,500 per person	$300 per person
$600 per family	$3,000 per family	$600 per family

YOUR IDENTIFICATION CARD

You must present your Blue Cross Blue Shield BlueCard PPO identification card to your medical provider when you receive services. There are instructions for filing claims on the back of the card.

Note that the NEI prefix must be included with your (the member’s) ID number when your medical claim is filed.

Your Medical Benefits

The following Medically Necessary expenses are covered under the Plan after you've met your deductible. When you visit a PPO provider, most of these expenses are covered at 100% of the contracted rate. When you visit an out-of-network provider, expenses are generally covered at 75% of the UCR Rate, meaning you're responsible for paying 25% coinsurance as well as an amount that your out-of-network provider charges that is more than the UCR Rate.
Note that not all Covered Expenses are listed. You should contact the Benefits Office for clarification or specific information if you are in need of a service or procedure that is not clearly described below.

Accident/Emergency Treatment

Benefits are payable for initial treatment within 72 hours of onset and must be for urgent care not available at a Physician's office.

Acupuncture

Benefits are payable when services are performed by the following providers: M.D., D.O., R.N., N.P., C.N.P., R.N.P., a licensed acupuncture specialist in the BlueCross BlueShield PPO Network or providers certified by the National Certification Commission for Acupuncture and Oriental Medicine.

Allergy Treatment

Physician's visits for allergy care are covered once every six months. Injections are covered as necessary.

Ambulance Services

Benefits are payable for emergency ambulance services to the nearest available facility when Medically Necessary and required to provide immediate treatment for an injury, Illness, or pregnancy. Ambulance service benefits are not payable when other transportation, such as an automobile, would provide sufficient transportation. Non-emergency transports are not covered.

Ambulatory Surgical Center

Benefits are payable when a surgical procedure is needed due to an injury, Illness, or pregnancy and performed in an Ambulatory Surgical Center. Payment will be made for services and supplies furnished by the Ambulatory Surgical Center within 72 hours before or after the surgical procedure is performed, and within seven days prior to the procedure in the case of diagnostic tests. Multiple surgical procedures reductions also apply to related facility fees. The Plan reserves the right to request a provider's acquisition invoice for implant items to determine an equitable reimbursement amount.

Anesthesia

Benefits are payable for anesthesia and the Covered Expenses for administering the anesthesia.

Biofeedback

Benefits are payable when services are rendered by an M.D., D.O. or Ph.D.

Birth Center

Benefits are payable for the care and treatment of a covered pregnancy of a Covered Individual in a birth center. Covered Expenses include charges by a Birth Center for Room and Board and charges for other services and supplies, anesthesia, and administering anesthesia.

Cardiac Rehabilitation

Benefits are payable for cardiac rehabilitation for heart related conditions and procedures such as angioplasty, heart attack, bypass surgery for up to 36 visits per episode. To qualify for coverage, a patient must:

- have recently had an acute myocardial infarction or cardiac surgery/catheterization; and
- the program must commence within six months of the patient being discharged from the hospitalization.

In order to be covered, the cardiac rehabilitation program must be under the guidance and supervision of a Physician or a group of Physicians who periodically review the standards and quality of treatment in order to be covered.

Chelation Therapy

Benefits are payable only for treatment of heavy metal poisoning.

Chemotherapy

Benefits are payable for chemotherapy and administering chemotherapy.

Chiropractic Services

Benefits are payable for covered Chiropractic manipulation services for up to three modalities per covered visit.
Note: Other than the amount applied to the patient's annual deductible, if any, the remaining patient liability amounts (non-covered services, coinsurance amounts) will not be applied to the patient's annual out-of-pocket maximum. Covered visits are cumulative for each calendar year, i.e. patient has received 12 visits out-of-network, therefore, the next visit will be paid as the 13th visit regardless of whether rendered In-Network or Out-of-Network.

Durable Medical Equipment

Benefits are payable for the purchase of durable medical equipment. Rental charges for durable medical equipment are covered to a maximum of the purchase price for the item. To be covered by the Plan, the item must be prescribed in writing by a Physician, primarily used for a medical purpose and can only be used by the person for whom it is intended. Examples of covered durable medical equipment are:

- Hospital-type medical equipment,
- wheelchairs,
- Hospital beds,
- oxygen,
- artificial limbs,
- crutches, and
- most custom-made braces.

Replacement of a corrective appliance is payable only if there is a change in the Covered Individual's physical condition making the current device inoperable and the Covered Individual is unable to perform normal daily activities, or if the device cannot be repaired. This rule is applicable to all covered durable medical equipment as set forth above.

TIME LIMITS

All covered Durable Medical Equipment has a specified time limit before the Plan will cover a similar replacement item. Check with the Benefits Office for specific limits.

Benefits are payable for base model, professionally adequate, least costly durable medical equipment only. All add-ons for comfort and/or convenience are not covered. Examples of non-covered durable medical equipment are:

- air conditioners,
- swimming pools,
- non custom-made braces,
- exercise equipment and chairs, and
- wigs, except for hair loss due to recent chemotherapy or radiation treatment. Coverage would then be allowed up to $500, once every five years.

Emergency Services

Benefits are payable within 72 hours of onset. Treatment for acute conditions such as but not limited to, burns, fractures, bleeding, difficult breathing, loss of consciousness, heart attack, stroke, severe high fever, etc. are covered. Treatment for non-emergency conditions such as colds, headache, back pain, chronic pain, etc. are not covered. A $50 Copayment is applicable to the facility fee each time you visit a Hospital emergency room. The Plan waives this Copayment if you are immediately admitted to the Hospital as an inpatient.

Genetic Testing

Coverage for genetic testing, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, and the associated genetic counseling, will be provided as Medically Necessary, subject to Medically Necessary peer review, as described below. Genetic testing is payable under this Plan for:

- state-mandated newborn screening tests for genetic disorders;
- covered pregnant women if the test or procedure is recommended by the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics; and if the test or procedure is Medically Necessary as determined by the Plan or its designee, including fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis;
- tests to determine a Covered Individual's sensitivity to FDA-approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity, and tests to determine the effectiveness of an FDA-approved drug for treatment of a Covered Individual, if the test is Medically Necessary as determined by the Plan or its designee;
- carrier testing for certain genetic disorders (such as Cystic Fibrosis) for Covered Individuals in any of the following groups, if the testing is Medically Necessary as determined by the Plan or its designee:
  - couples seeking prenatal care; or
  - couples who are planning a pregnancy; or
  - persons with a family history of the genetic disorder in question; or
  - persons with a 1st degree relative identified as a carrier; or
  - reproductive partners of persons with the genetic disorder in question;
- the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in Covered Individuals who meet all the following conditions:
  - the testing method is considered scientifically valid for identification of a genetically linked inheritable disease; and
  - the Covered Individual displays clinical features/symptoms of a genetically linked inheritable disease, or the Covered Individual is at direct risk (e.g., family history, first or second-degree relative) for the development of a genetically linked inheritable disease (pre-symptomatic); and
  - the results of the test will directly impact clinical decision-making, the clinical outcome or the treatment being delivered to the Covered Individual.

GENETIC TESTING SERVICES

The Plan will provide Medically Necessary coverage for both pre-test and post-test genetic counseling for those Covered Individuals undergoing genetic testing if provided by a licensed Physician or a licensed or certified genetic counselor and provided in conjunction with a genetic test that is payable by this Plan.

Genetic testing other than state-mandated newborn screening requires precertification through the Plan's Utilization Management Review program (see page 41).

Hospital Charges

Benefits are payable when you or your eligible dependent is confined in a Hospital due to injury, Illness, or pregnancy. Covered Expenses include Hospital room charges for a semi-private room, intensive care room, or ward. If you stay in a private room, the maximum amount covered by the Plan will be the semi-private room rate. Payment will also be made for miscellaneous or ancillary charges that include other Hospital Services and Supplies, and anesthesia, including administration.

Hyperbaric Oxygen Therapy/Decompression Treatment

Benefits are payable for up to 10 treatments for the following conditions only: Carbon Monoxide Poisoning, Chronic Osteomyelitis, Acute Ischemia, Decompression Sickness, Gas Embolism, Gas Gangrene, Soft Tissue Infections. All treatments require a letter of Medical Necessity prior to the commencement of therapy. Topical hyperbaric oxygen therapy is not covered for treatment for any condition not listed above.

Laboratory Tests and X-Rays

Benefits are payable for laboratory tests, x-rays, and other related diagnostic procedures performed when prescribed by a duly qualified Physician for diagnosis of an injury, Illness, or pregnancy. No payment will be made under this section for laboratory tests or x-rays to the teeth or gums except when performed because of a recent injury to natural teeth.

Medical and Surgical Supplies

Benefits are payable for the following Medically Necessary medical and surgical supplies that are prescribed by a duly qualified Physician:

- An appliance that replaces a lost body organ or part and is comparable to an artificial limb or eye;
- Oxygen and the charges for administering it, including the rental of necessary equipment;
- Rental of a wheelchair or hospital style bed;
- Rental of a device to help breathing when you are paralyzed;
- Blood or blood plasma if not donated or replaced; and
- Surgical supplies, including bandages and dressings.

Nutritional Counseling

Benefits are payable for Medically Necessary nutritional counseling when prescribed by a qualified licensed Physician for the treatment of chronic disease states in which such counseling has a therapeutic role, i.e., cardiovascular disease, diabetes, hypertension, kidney disease, gastrointestinal disorders, seizures, and eating disorders. Such nutritional counseling services are only covered, however, if provided by a registered dietician, licensed nutritionist or other qualified licensed health professional such as a registered nurse trained in nutrition. To be eligible for this benefit, you must contact the Benefits Office prior to starting nutritional counseling services. The Benefits Office will ask you or your prescribing Physician to submit detailed medical records to substantiate this counseling. The Benefits Office will then submit these records to Carewise Health for a Medical Necessity determination. If approved, participation in the Plan's Case Management program is required (see page 41).

Nutritional counseling is not covered for weight loss programs, chronic fatigue syndrome, attention-deficit hyperactivity disorder or any other condition for which such counseling has not been proven to be of value or nutritionally related.

Occupational Therapy

Benefits are payable for the medical care and treatment by a registered occupational therapist when prescribed by a duly qualified Physician. Charges for an office visit performed by a registered occupational therapist are not covered. Treatment plans of extensive duration will be reviewed for Medical Necessity and appropriateness of care.

Organ Transplants

Benefits are payable for certain organ transplants when services are provided through a facility in the OptumHealth Complex Medical Conditions Transplant Network. Transplant facilities across the country have been selected and screened by OptumHealth for their proficiency in performing heart, kidney, bone marrow and liver transplants. For more information, see page 49.

Physical Therapy

Benefits are payable for the medical care and treatment by a registered physical therapist when prescribed by a duly qualified Physician. Charges for an office visit performed by a registered physical therapist are not covered. Treatment plans of extensive duration will be reviewed for Medical Necessity and appropriateness of care.

Physician Services

Benefits are payable for charges by a duly qualified Physician when Medically Necessary due to injury, Illness, or pregnancy, as follows:

- Hospital or office visits;
- Emergency room treatment;
- Home visits when you are house confined; and
- Surgery.

Excluded Physician Services Expenses:

- Services performed for dental or vision care purposes unless due to an injury (services may be covered under dental or vision care benefits); or
- Consultation charges from a specialist after two visits by the specialist.

Radiation Therapy

Benefits are payable for radiation therapy when prescribed by a duly qualified Physician for the treatment of an Illness. Radiation therapy includes x-ray, radon, radium, and radioactive isotopes.

Social Worker's Services

Benefits are payable for a Social Worker's services when performed by a licensed Social Worker (L.S.W.) who is licensed in the jurisdiction in which services are rendered. Coverage and limitations are described in detail in the mental health section beginning on page 44.

Speech Therapy

Benefits are payable for speech therapy prescribed by a duly qualified Physician and performed by a licensed speech therapist for up to a maximum of 30 visits per calendar year to restore speech loss or impairment due to one of the following conditions:

- Injury, Illness or pregnancy;
- Cerebral Vascular Accident (C.V.A.);
- Congenital anomaly; or
- Surgery, radiation therapy, or other treatment that affects the vocal cords.

Surgery

Benefits are payable for surgery performed by a duly qualified surgeon when Medically Necessary, as the result of an injury, Illness, or pregnancy. This benefit is payable regardless of where the surgery is performed. Benefits are not payable for incidental surgery performed during surgery that would not have otherwise been performed. Benefits payable for an assistant surgeon during a covered surgery are limited to an allowed amount of 20% of the PPO fee schedule for a PPO provider or an allowed amount of 20% of the UCR Rate for a non-PPO provider. The need for an assistant surgeon must be Medically Necessary and the assistant must be a duly qualified Physician or licensed surgical/physician assistant.

- **Multiple Surgery**

  Multiple surgery is when more than one surgical procedure is performed through the same incision or the same operative site by the same surgeon or co-surgeon during the same operative session. Benefits payable for multiple surgeries are allowed at 100% for the primary procedure, 50% for the secondary procedure and 25% for all subsequent procedures.

Percentages indicated above will be based on the PPO fee schedule for a PPO provider or the UCR Rate for a non-PPO provider, whichever is applicable. For non-PPO providers, the applicable 25% coinsurance will be applied after the multiple surgery adjustments described above are applied to the UCR Rate.

- **Reconstructive Surgery**

  Benefits are payable for reconstructive surgery performed to improve the function of a body part when the malfunction is the direct result of an injury, birth defect, scar tissue, or surgery to treat an injury or Illness. Benefits are also payable for reconstructive breast surgery following a mastectomy.

Precertification

Precertification is required for all surgeries performed in an inpatient, outpatient or Ambulatory Surgical Center. Precertification is also required prior to all non-emergency hospital admissions and within 48 hours of an emergency hospital admission. Your provider must contact the Plan's precertification vendor at 1-800-634-4832 for approval. Surgical, hospital and related expenses submitted to the Plan without a valid precertification will not be covered. Precertification is also required for all pain management and Home Health Care services.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal (or state) law, group health plans and health insurance issuers generally may not restrict benefits for length of hospitalization in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, this Plan will provide the following coverage for a member or eligible dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction surgery in connection with the mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.

Wellness Benefits

The Plan offers several programs and great health care benefits to keep you and your family healthy.

FAST FACTS:

- **The Plan offers wellness tests and screening for children and adults based on the American Medical Association's recommended schedule of services.**
- **Benefits are payable for the Adult and Child Wellness tests and screening at 100% of the contracted rate when you visit a PPO provider. If you visit an out-of-network provider, benefits are payable at 75% of the UCR Rate or 100% of the UCR Rate if you are considered "out-of-area."**
- **Covered wellness services for you and your eligible dependents are not subject to the Plan's annual deductible if you use a BlueCross BlueShield BlueCard PPO Provider or if you are considered out-of-area.**

ADULT WELLNESS PROGRAM

BASELINE TESTS AND SCREENING		
AGES 19-39	AGES 40-49	AGES 50+
Annually	**Annually**	**Annually**
Mammography	Cholesterol Screening	Cholesterol Screening
Pap Test	Complete Blood Count	Complete Blood Count
Pelvic Exam (females)	General Physical Exam	General Physical Exam
Gonorrhea Screening (females)	Gonorrhea Screening (females)	Gonorrhea Screening (females)
Immunizations (as needed)	Immunizations (as needed)	Immunizations (as needed)
Every Two Years	Mammography	Mammography
Bone Density Testing	Pap Test	Occult Blood Test
Cholesterol Screening	Pelvic Exam (females)	Pap Test
Complete Blood Count	Prostate Exam (males)	Pelvic Exam (females)
General Physical Exam	Rectal Exam	Prostate Exam (males)
Prostate Exam (males)	Tonometry (glaucoma)	Rectal Exam
Tonometry (glaucoma)	Urinalysis	Tonometry (glaucoma)
Urinalysis	**Every Two Years**	Urinalysis
Every Ten Years	Bone Density Testing	**Every Two Years**
Diphtheria-Tetanus Immunization	**Every Ten Years**	Bone Density Testing
	Diphtheria-Tetanus Immunization	**Every Three Years**
		Colon Sigmoidoscopy
		Every Ten Years
		Diphtheria-Tetanus Immunization

CHILD WELLNESS PROGRAM

BASELINE TESTS AND SCREENING	
AGES 0 TO 2ND BIRTHDAY	**AGES 2+ TO 19TH BIRTHDAY**
Frequency as recommended by Physician:	**Frequency as recommended by Physician:**
Diphtheria-Tetanus Immunization	Diphtheria-Tetanus Immunization
Hematocrit	Hepatitis Immunization
Hemoglobin (HGB)	Measles Mumps Rubella Immunization
Hepatitis Immunization	Polio Vaccine
Measles Mumps Rubella Immunization	Tuberculosis Immunization
Phenylalanine (PKU)	
Polio Vaccine	**Annually**
Tuberculosis Immunization	Cholesterol Screening
Urinalysis	Hematocrit
	Hemoglobin (HGB)
Preventive Exams	Lead Screening
■ 8 in first year	Metabolic Screening
■ 3 in second year	Pelvic Exam including testing for Chlamydia and Gonorrhea (females 18 and 19)
	Phenylalanine (PKU)
Annually	Preventive Exam
Lead Screening	Tuberculin Testing
Metabolic Screening	Urinalysis
Tuberculin Testing	

DIABETES SELF-MANAGEMENT TRAINING PROGRAM

The Plan considers a Diabetes Self-Management Training Program as Medically Necessary for eligible persons diagnosed with diabetes when ALL of the following criteria are met:

- The patient has a diagnosis of diabetes mellitus.
- The program has been prescribed by a licensed Physician actively treating the patient.
- The program consists of services of recognized healthcare professionals (e.g., Physicians, registered dieticians, registered nurses or other health professionals) who are certified diabetes educators.
- The program is designed to educate the patient about Medically Necessary diabetes self-care.

The Plan will cover the following training services (copied from the National Institutes of Health's National Diabetes Education Program):

- A total of 10 hours of initial training in 12 months (covered once per lifetime).
- An additional 2 hours of follow-up training each calendar year after completion of the initial training (you must get a new prescription from your Physician each year).

Where to find a diabetes self-management training program?

- Your treating Physician may be able to supply you with a program.
- Your local community hospital.
- Contact the American Diabetes Association at 1-800-342-2383 or visit the Association's website at www.diabetes.org/education/eduprogram.asp to find a training program located near you that is recognized for excellence in diabetes education.

HEALTH MANAGEMENT PROGRAM

Carewise Health administers the Plan's Disease Management, Case Management, and Utilization Review programs. The phone number for all three programs is 1-800-634-4832.

- Disease Management is a system of coordinated health care interventions and communications designed to support: (i) patient self-care; (ii) the Physician/patient relationship utilizing evidence-based medical guidelines, and (iii) patient empowerment strategies. Nurse coaches work with patients individually to develop highly personalized care plans. Nurse coaches also ensure patients have the knowledge and resources to manage their conditions. These specially trained nurses and clinically proficient health educators help patients build the skills they need to take an active role in managing their conditions. Conditions within the Disease Management program include asthma, atrial fibrillation, congestive heart failure, COPD, coronary artery disease, diabetes, hyperlipidemia (high cholesterol), hypertension and low back pain.
- Case Management is a collaborative process structured to address catastrophic Illness and complex health needs of patients. Case managers work with a patient's medical care providers to coordinate services associated with treatment, discharge or return to home, and post care needs. In addition, case managers provide assistance with seeking specialized treatment, address the psychological needs of the patient and the patient's family, and intervene when necessary to achieve desired medical outcomes for the patient. Complex medical cases that are addressed by case managers include end-stage renal disease, cancer, high-risk pregnancies, spinal cord injuries, stroke, and other conditions.
- Utilization Review is a process required by the Plan to review specific medical services to ensure the necessity of medical care and provide review of medical treatment pre- and post-care delivery. The process evaluates the efficiency, appropriateness, necessity, and efficacy of health care services. Utilization review is required for all inpatient hospital admissions, all surgeries, all Home Health Care services and all pain management services.

For more information, please contact the Benefits Office.

SMOKING CESSATION PROGRAM

The Plan offers the Quit For Life® Program at no cost to you, your Spouse and your eligible dependents who are age 18 or older. When you call 1-866-QUIT-4-LIFE an expert Quit Coach® will help you build a Quitting Plan based on your unique needs and lifestyle. You'll receive as much one-on-one support as you need over the phone from coaches who specialize in helping people quit tobacco.

When you enroll, you'll also receive:

- An easy-to-use printed Quit Guide you can reference in any situation to help you stick with your Quitting Plan.
- Free nicotine replacement therapy (patch or gum) if such replacement therapy is a part of your Quitting Plan. You'll also receive advice on which type, dose, and duration of use that is right for you.
- Membership to Web Coach®, a private online community where you can complete activities, watch videos, track your progress, and join in discussions with other Participants.

Quitting tobacco isn't easy, but the Quit For Life Program® can help. Your chances of quitting successfully may be 9 times better in the program than if you try quitting on your own.

Call 1-866-QUIT-4-LIFE (1-866-784-8454), or log on to www.QuitNow.net/IUEC for details or to enroll.

Extended Care

The NEI Health Benefit Plan provides payment for Home Health Care, Skilled Nursing Services, Hospice Care and Convalescent/Rehabilitation/Long-Term Acute Care Facility confinement.

FAST FACTS:

- **The Plan provides payment for extended care, such as care in your home, Skilled Nursing Services, Hospice care and Convalescent/Rehabilitation/Long-Term Acute Care Facility when Medically Necessary and prescribed by a duly licensed Physician.**
- **Covered Expenses for extended care are paid at 100% of the contracted rate when you receive care from a PPO provider. The Plan pays 75% of charges up to the UCR Rate if you are considered "out-of-area".**

HOME HEALTH CARE

The Plan provides benefits for care in your home—when prescribed by a duly licensed Physician—for treatment provided by a Home Health Care Agency within one week of a hospital stay.

The Plan pays for Home Health Care expenses for up to 80 visits in a calendar year. Each visit by a member of a Home Health Care Agency or each four hours of Home Health Care services is considered one visit.

What's Covered

- Medically Necessary part-time or intermittent nursing care by, or under the supervision of, a registered graduate nurse (R.N.);
- Physical therapy, occupational therapy and speech therapy as ordered by the patient's attending Physician and performed by a licensed qualified therapist; and
- Medical supplies, Prescription Drugs and medications prescribed by a duly qualified Physician and laboratory services by, or on behalf of, a Hospital to the extent they would have been covered under the Plan if you had remained in the Hospital.

What's Not Covered

- Custodial Care;
- Part-time or intermittent Home Health Care aide services consisting primarily of caring for the patient; and
- Comfort items

SKILLED NURSING SERVICES

Skilled Nursing Services are those Medically Necessary services of an R.N. and a licensed practical nurse L.P.N. when prescribed by a duly qualified Physician.

What's Not Covered

Nursing services are not covered when you are hospitalized.

HOSPICE CARE

The Plan pays benefits for Hospice care for up to 12 months if you or your eligible dependent is confined to a Hospice. The attending, duly qualified Physician must certify that you (or your dependent) are terminally ill with 12 months or fewer to live.

What's Covered

- Part-time or intermittent nursing care by, or under the supervision of, a registered graduate nurse (R.N.);
- Services of a home health aide in a Hospice;
- Social services by, or under the supervision of, a Social Worker; and
- Pastoral counseling by a licensed minister, licensed Social Worker, or licensed counselor.

CONVALESCENT/REHABILITATION/LONG-TERM ACUTE CARE FACILITY CARE

Benefits are payable when a Covered Individual is confined in a Convalescent/Rehabilitation/Long-Term Acute Care Facility within 14 days of a Hospital stay of at least 3 days due to the same injury, Illness, or pregnancy. Benefits are payable for a maximum of 70 days per confinement. Medically Necessary confinements at a long-term acute care facility are also covered with these same guidelines and limitations. Pre-certification is required when the Plan is the primary payer and/or when other primary coverage exhausts its benefit.

Successive periods of confinement in a Convalescent/Rehabilitation/Long-Term Acute Care Facility will be considered one period of confinement unless the confinements are separated by more than 14 days or the later confinement is due to an injury, Illness, or pregnancy-related medical condition entirely unrelated to the earlier one. Benefits are payable for Room and Board and other services and supplies, and for services provided by an anesthesiologist, pathologist or radiologist.

Conditions for Payment:

All of the following conditions must be met for benefits to be paid under the Convalescent/Rehabilitation/Long-Term Acute Care Facility benefit:

- Certification by a duly qualified Physician on the first day of confinement and at least once every 31 days thereafter for as long as care in a Convalescent/Rehabilitation/Long-Term Acute Care Facility is required;
- Medical care and treatment prescribed by a duly qualified Physician;
- Continuing supervision by a duly qualified Physician, including a personal examination at least once every 31 days as long as care in a Convalescent/Rehabilitation/Long-Term Acute Care Facility is required.

What's Not Covered

Benefits are not payable for:

- any confinement, service, Prescription Drugs or medication that has not been recommended by a duly qualified Physician; or
- any Custodial Care or personal comfort items.

Mental Health and Substance Abuse

You and your eligible dependents are covered for the inpatient and outpatient treatment of mental health and substance abuse.

FAST FACTS:

- **The Plan's provider for mental health and substance abuse treatment is Beacon Health Options.**
- **You can contact Beacon Health Options at any time by calling 1-800-331-4824.**
- **You do not have to meet a deductible before the Plan will pay benefits for your treatment.**

Beacon Health Options has a large network of providers and clinical facilities offering a wide variety of specialists including hospitals, outpatient facilities, residential settings, psychiatrists, Psychologists, and licensed therapists such as Social Workers with advanced degrees.

You can contact Beacon Health Options 24 hours a day, seven days a week on their Clinical Referral Hot Line at 1-800-331-4824 for a referral or, in case of an emergency, to arrange to get you to the nearest emergency facility.

What You Need To Do:

If you need assistance, contact Beacon Health Options at 1-800-331-4824 to speak with a registered psychiatric nurse or master's level Social Worker (M.S.W.) who will refer you to a mental health professional or facility.

Tell your provider that you are covered by Beacon Health Options. If you receive treatment from an out-of-network provider, submit your claims to:

Beacon Health Options
P.O. Box 1347
Latham, NY 12110

YOUR MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS AT-A-GLANCE

	IN-NETWORK (BEACON HEALTH OPTIONS PROVIDER)		OUT-OF-NETWORK	
	Plan Pays	You Pay	Plan Pays	You Pay
Mental Health Inpatient Care	100% of Contracted Rate	0%	75% of UCR Rate	25% of the UCR Rate plus amount over UCR Rate
Mental Health Outpatient Care	100% of Contracted Rate	0%	75% of UCR Rate	25% of the UCR Rate plus amount over UCR Rate
Substance Abuse Inpatient and Outpatient Care	100% of Contracted Rate	0%	75% of UCR Rate	25% of the UCR Rate plus amount over UCR Rate

For a more complete listing of services that are covered under the mental health and substance abuse benefits, see the schedule of benefits on pages 10 and 11.

What's the Difference Between the Contracted Rate and the UCR Rate?

Providers in the Beacon Health Options network have a contractual agreement to accept the negotiated fee as the total covered amount for services. In-network providers cannot bill you for any differences between their charges and the contracted charges. Out-of-Network providers services will be paid at the UCR Rate.

Save Money with Beacon Health Options Providers

The example below shows how you can save money when you use an in-network provider.

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Example charge for outpatient mental health care	$150 (contracted rate)	$250
UCR Rate	N/A	$200
Amount Plan will cover	100% of contracted rate Plan pays $150	75% of the UCR Rate: 75% x $200 = Plan pays $150
Amount you must pay	You pay $0	25% of the UCR Rate: 25% x $200 = $50 plus charge in excess of UCR Rate: $50 You pay $100

NEED TO FIND A BEACON HEALTH OPTIONS PROVIDER?

Visit the Beacon Health Options website at www.achievesolutions.net or call them at 1-800-331-4824.

WHAT'S NOT COVERED

The Plan does not cover the following services under the mental health and substance abuse benefits

- more than one professional service in one day;
- services performed by out-of-network providers who do not satisfy Beacon Health Options's credentialing process requirements; or
- outpatient psych testing (performed by a network provider) for a mental health and substance abuse diagnosis that is not precertified.

MEMBER ASSISTANCE PROGRAM

As a supplement to the mental health and substance abuse services provided by Beacon Health Options, the Member Assistance Program (MAP) is available at no cost to all Participants. The Member Assistance Program can be reached 24 hours a day, seven days a week, by calling 1-800-331-4824.

EXCEPTED BENEFIT STATUS OF THE MEMBERS ASSISTANCE PROGRAM

A Participant may elect to waive Member Assistance Program benefits coverage under the Plan. To elect to opt out of the Plan's MAP benefits coverage, a Participant must notify the Plan in writing. An election not to have MAP benefits coverage may be revoked by the Participant at any time by submitting a written request to the Plan. Coverage will resume for covered services rendered on the first of the month after the revocation of the waiver is received by the Benefits Office. You should note, electing to opt out of Member Assistance Program benefit coverage will have no impact on the rate of contributions you or your Employer must make to the Plan or the amount of your self-payment to maintain extended benefits coverage.

WHAT'S COVERED

- Up to eight sessions with a Member Assistance counselor per issue per year. Problems that cannot be resolved within eight sessions will be covered, to the extent eligible, under the Plan's traditional mental health benefit coverage.
- Legal and Financial Consultation: The MAP will help members through legal or financial issues by referring them to a certified/licensed professional in their area. The benefit allows for a free thirty minute consultation with a professional. (Referrals may be available to certified/licensed professionals who have agreed to provide 25% discounted services directly to the Participant if services continue. Such discounted services are provided directly by the professional and are not paid by the Plan.) Legal services against the Plan, the National Elevator Industry Pension Plan, the Elevator Constructors Annuity and 401(k) Retirement Plan, the National Elevator Industry Educational Program, the Elevator Industry Work Preservation Fund, the Trustees or Employees of any of these plans, any service provider to any of these plans, any Contributing Employer, the International Union of Elevator Constructors or any IUEC Local are excluded from coverage. Any services related to starting or maintaining a business enterprise are also not covered.

Prescription Drugs

NEED TO FIND A PARTICIPATING PHARMACY?

Most pharmacies participate in the Express Scripts Prescription Drug program.

To locate a provider near you, visit the Express Scripts website at www.expressscripts.com.

The Trustees contract with Express Scripts to serve as the Plan's Prescription Benefit Manager. You may purchase your Prescription Drugs at a retail pharmacy, or through the Plan's home delivery program.

FAST FACTS:

- **You may purchase up to a 30-day supply of Prescription Drugs for a 20% Copayment at participating retail pharmacies. Minimum and maximum Copayments apply.**
- **The maximum Prescription Drug Copayment is $40 for retail and $50 for home delivery.**
- **You may receive up to a three-month supply for a $10 Copayment on most generic medications through the home delivery program.**

YOUR PRESCRIPTION DRUG BENEFITS AT-A-GLANCE

	GENERIC	PREFERRED BRAND-NAME	NON PREFERRED BRAND-NAME	SUPPLY	REFILLS
Retail Pharmacy	20% of cost, minimum $5 Copayment	20% of cost, minimum $15 Copayment	20% of cost, minimum $30 Copayment	up to 30-day supply	up to two refills
Home Delivery	$10 Copayment	$30 Copayment	$50 Copayment	up to 90-day supply	up to three refills

NOTE: Retirees whose pensions became effective on or before January 1, 1984 are eligible for Prescription Drug benefits as follows: $5 Copayment for generic drugs or $10 Copayment for brand name drugs for a 30-day supply from a retail pharmacy; or $10 Copayment for generic drugs or $20 Copayment for brand name drugs for a 90-day supply through the mail order program.

RETAIL PHARMACY

When you purchase your Prescription Drugs at a pharmacy that participates in the Express Scripts network (Participating Pharmacy), show your Prescription Drug ID card and make the appropriate Copayment. Your Copayment is 20% of the cost with a minimum Copayment of $5 for generic drugs, $15 for preferred brand-name drugs or $30 for non-preferred brand-name drugs. The maximum Copayment for any prescription is $40. You do not have to send in a claim form when you use a Participating Pharmacy.

Non-Participating Pharmacy

The Plan provides a benefit if you have your prescription filled at a non-Participating Pharmacy. If your pharmacy is not a Participating Pharmacy, you must pay your pharmacy directly and file a claim with Express Scripts. Express Scripts will send you a reimbursement check for your Prescription Drug, minus your Copayment. Contact Express Scripts for a claim form.

Generic Drugs

Generic drugs are "therapeutic equivalents" and, by law, must contain identical active chemical ingredients of the brand name drugs they replace. For most people, most of the time, a generic will give them the same results as a brand-name drug.

GCN BASED RETAIL PHARMACY LIMIT PROGRAM

If you have a prescription filled by a retail pharmacy and then have that same Prescription Drug or a Prescription Drug with the same Generic Code Number (GCN) as that Prescription Drug refilled two more times through a retail pharmacy, you must use the Express Scripts home delivery program for your third refill or you will be charged 100% of the cost of the Prescription Drug (or a Prescription Drug with the same GCN). Although the refill will be "flagged" by Express Scripts to caution that no benefit will be paid for a retail pharmacy refill even if the Prescription Drug has been changed to a generic drug or presented to a different retail pharmacy, you will be responsible for the entire cost of the refill if you go to a retail Pharmacy rather than to the Express Scripts home delivery program for your third refill.

HOME DELIVERY PROGRAM

The Plan offers a home delivery program to make purchasing your maintenance Prescription Drugs easier. Maintenance drugs are those medications that you take on a regular basis, such as medicine for diabetes, high blood pressure or heart conditions.

Your Copayment for prescriptions through the mail is $10 for generic drugs or $30 for preferred brand-name drugs and $50 for non-preferred brand-name drugs for up to a 90-day supply. Most Prescription Drugs can be ordered and sent directly to your home within 48 hours of receipt of your order. You can order refills 24 hours a day, seven days a week by visiting www.express-scripts.com.

What You Need To Do:

Retail Pharmacy

- Bring your prescription and your prescription ID card to your pharmacy.
- Make the applicable Copayment to receive your Prescription Drug.

Home Delivery Program

- You may request a mail order form and envelopes by calling Express Scripts at 1-866-830-3890 or through the Express Scripts website www.express-scripts.com.
- Obtain a prescription from your doctor for up to a 90-day supply of the Prescription Drug plus up to three refills if necessary. The prescription must include:
  - the patient's full name;
  - the doctor's name, phone number and address;
  - exact strength, quantity and dosage; and
  - diagnosis, if required for that drug.
- Complete the form and mail it in with your prescription and required Copayment.

PRIOR AUTHORIZATION

Certain Prescription Drugs that have not been previously authorized will require a review by Express Scripts before being treated as Covered Expense. The Participant should check with Express Scripts for a current list of Prescription Drugs covered by the Prior Authorization program.

DOSE OPTIMIZATION

Many Prescription Drugs are available at various strengths and their total cost may vary depending on the dosage strength. At times, for example, it may be more cost-effective to receive a daily dose of a 100 mg tablet versus a daily dose of two 50mg tablets. If this situation applies to the Prescription Drug that you're taking, Express Scripts will notify you of your options.

WHAT'S COVERED

- Most Prescription Drugs that are prescribed by a Physician and are Medically Necessary for the care or treatment of an injury, Illness or pregnancy.
- Erectile dysfunction drugs, for not more than eight pills per 30-day supply for males 18 and older. Not available through the home delivery program.
- Oral contraceptives, under both retail and home delivery programs.
- Depo-Provera and Lunelle injections, if purchased through retail or home delivery programs and then taken to a Physician for administration.

FORMULARY CHANGES AND PRIOR AUTHORIZATION

To help control Prescription Drug costs and to help maintain the long-term viability of the Plan's Prescription Drug program, from time to time the Trustees may agree to accept changes to Express Scripts' formulary that may result in the removal of medications from its formulary or require you to obtain prior authorization. This may result in the Plan not covering certain Prescription Drugs removed from the formulary or denying claims for medications in cases where you do not obtain prior authorization for Medical Necessity. An updated list of drugs not covered by the Plan due to changes in Express Scripts' formulary and an updated list of medication requiring prior authorization are available online at www.express-scripts.com, or you may request a copy of these lists by calling Express Scripts at 866-830-3890. If you have been prescribed a Prescription Drug that the Plan ceases to cover because Express Scripts removes the Prescription Drug from its formulary, you should receive notice in writing of such change; however, the change will become effective even if you do not receive notice prior to the effective date of such change.

COMPOUND MANAGEMENT PROGRAM

The Plan is enrolled in Express Scripts' Compound Management Program. Under the Compound Management Program, certain compound medications will not be covered by the Plan. To help eliminate unnecessary waste, the Plan also may enroll in related Express Scripts' programs whereby the Plan will not cover similar medications including but not limited to high cost pain patches and compounding kits. If you or your doctor have any questions about whether a specific compounded medication, pain patch, compounding kit or similar medication is covered by Express Scripts, you should contact Express Scripts directly at 866-830-3890.

CLINICAL REVIEW PROGRAMS

To help control Prescription Drug costs for you and the Plan, from time to time the Plan will participate in certain Express Scripts clinical review programs. These clinical review programs may require that you have certain prescriptions filled by designated pharmacies (including specialty pharmacies), that you have your prescription filled through the Plan's home delivery program or that you obtain prior authorization before having your prescription filled. If your provider prescribes a drug that is subject to Express Scripts' clinical review programs, you will be notified by Express Scripts.

FRAUD, WASTE AND ABUSE PROGRAM

Express Scripts monitors Physician and patient Prescription Drug utilization patterns to help the Plan reduce wasteful spending and health risks associated with fraud, waste and abuse of certain Prescription Drugs. The program identifies potential problem prescribers and unusual or excessive utilization patterns. When it identifies an unusual pattern of Prescription Drug use, Express Scripts may restrict the filling of that Prescription Drug to one designated pharmacy or restrict a patient to a single Physician for the prescribing of Prescription Drugs.

WHAT'S NOT COVERED

- Over-the-counter drugs, vitamins and dietary supplements.
- Drugs removed from the Express Scripts formulary and not covered by the Plan (see above).
- Prescriptions that require prior authorization (see above) if you did not obtain such prior authorization.
- Contraceptive creams, jellies, foams or devices, except for diaphragms and IUDs.
- Drugs labeled "Caution—limited by Federal Law to investigational use."
- Drugs with the sole purpose of promoting or stimulating hair growth or promote hair removal.
- Experimental drugs.
- Legend vitamins for non-medical purposes.
- Liquid protein supplements.
- Medication that is to be taken by, or administered to, you or an eligible dependent while a patient in a hospital, skilled nursing facility, nursing home or similar facility.
- Therapeutic devices or appliances.
- Smoking Deterrents/Nicotene Replacement Therapy.
- Compounded medications which contain ingredients that are excluded under Express Scripts' Compound Management Program (see above).

DISCONTINUATION OF PRESCRIPTION BENEFITS FOR MEDICARE-ELIGIBLE RETIREES WHO ENROLL IN MEDICARE PART D

The Plan's Prescription Drug program for Medicare-eligible Participants is actuarially comparable to the federal prescription drug program called Medicare Part D. Therefore, if a Retiree or his/her Spouse enrolls in a Medicare Part D Prescription Drug Plan, he or she may not participate in the Plan's prescription drug program.

The Trustees have determined, with the assistance of an actuary, that the Plan's Prescription Drug program for Medicare-eligible Participants is "actuarially equivalent" to Medicare Part D. This means that, on average, the Plan's benefits are equal to or better than the standard Medicare Part D Prescription Drug Plan. Accordingly, a Retiree who enrolls in a Medicare Part D Prescription Drug Plan will be excluded from participation in the Plan's Prescription Drug program as of the effective date of his/her enrollment in the Medicare Part D Prescription Drug Plan.

If a Retiree enrolls in a Medicare Part D Prescription Drug Plan, his/her Spouse and eligible dependent(s) will continue their participation in the Plan's Prescription Drug program as long as they remain eligible for coverage in the Plan and do not enroll themselves in a Part D Plan. If a Retiree's Spouse enrolls in a Medicare Part D Prescription Drug Plan, the Retiree and his/her other eligible dependent(s), if any, will continue their participation in the Plan's Prescription Drug program as long as they remain eligible for coverage in the Plan and do not enroll themselves in a Part D Plan.

Participants who are excluded from participation in the Plan's Prescription Drug program, however, will still be entitled to receive medical and other benefits (as applicable) offered by the Plan for Retirees, for which they are otherwise eligible, regardless of their participation in any Medicare Prescription Drug Plan. Moreover, notwithstanding the above, and in accordance with Medicare's payment rules, Covered Individuals with End Stage Renal Disease will not be excluded from the Plan's Prescription Drug coverage if they enroll in a Medicare Part D Prescription Drug Plan.

Active Employees and their eligible dependents who are Medicare-eligible need not sign up for a Medicare Part D Prescription Drug Plan, as they may still obtain prescription benefits from the Plan under the terms of this Summary Plan Description.

Organ Transplants

Benefits are payable for certain organ transplants when services are provided through a facility in the OptumHealth Complex Medical Conditions Transplant Network. Transplant facilities across the country have been screened and selected by the OptumHealth Complex Medical Conditions Transplant Network for their proficiency in performing heart, kidney, bone marrow, liver, lung, intestinal and pancreas transplants. To use the OptumHealth Complex Medical Conditions Transplant Network, you or your Physician must contact the Plan's Case Manager at 800-634-4832.

COVERED EXPENSES RELATED TO ORGAN TRANSPLANTS

- Donor match evaluation for immediate family members and up to five persons not related to the patient;
- Donor acquisition and transportation expenses;
- Transplant evaluation tests;
- Transplant surgical fees and related facility fees; and
- Post-transplant follow-up care for up to 12 months beginning with the initial hospital admission for transplant treatment.

TRAVEL AND LODGING

The following benefits are available when you use a OptumHealth Complex Medical Conditions Transplant Network facility and your transplant has been approved by the Plan's case manager:

- Reimbursement for travel expenses to and from the site of the transplant facility, based on the cost of a regular coach roundtrip ticket for the patient and one travel companion. A travel companion must be an adult family member or other adult whose accompaniment is considered necessary for the well-being of the patient. When the facility is near the patient's home, travel expenses for the patient will be reimbursed at the rate established by Internal Revenue Service guidelines for reimbursement of travel and lodging expenses for medical care.
- Lodging is covered and reimbursed at 100% up to $50 per day for the patient and up to $50 per day for one adult travel companion whose presence is necessary for the patient's wellbeing, at a hotel or place of lodging associated with the transplant facility. Lodging coverage will be provided for the patient and one travel companion before, during and after the transplant.
- Travel and lodging expenses up to $50 per day for the patient and up to $50 per day for one adult travel companion whose presence is necessary for the patient's well-being, for follow-up treatment at the transplant facility will be reimbursed for a maximum of 12 months from the initial date of the hospital admission.

Dental Care

Healthy teeth and gums are an important part of your overall health. That's why the Health Benefit Plan offers you the flexibility of being able to visit any Dentist you'd like. You may choose to visit a Dentist in the Guardian DentalGuard Preferred Select PPO network for even greater savings on dental care.

WHAT ARE TYPE I, TYPE II AND TYPE III SERVICES?

Type I services are preventive and diagnostic, such as cleaning and x-rays. Type II services include fillings and root canal work. Type III services include tooth repair, crowns and dentures. For a more complete listing, *see pages 52-53.*

FAST FACTS:

- **Whenever you or an eligible family member needs dental care, you are free to choose any Dentist or specialist you wish.**
- **You may visit a Dentist in the Guardian DentalGuard Preferred Select PPO network, which may save you money on out-of-pocket costs.**
- **You do not need to meet a deductible to receive preventive or diagnostic dental care.**

Your dental benefits provide coverage for the care or treatment of the teeth and gums including:

- preventive and diagnostic services such as cleaning, fluoride treatment, oral exams, sealants, and x-rays;
- restorative services, extractions, oral surgery, bridgework and dentures; and
- Orthodontia services and supplies.

YOUR DENTAL BENEFITS AT-A-GLANCE

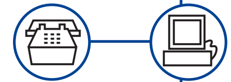
Annual Deductible	Per person—$50; Per family—$100
Annual Maximum Benefit (excluding Orthodontia)	$1,875 per Covered Individual over the age of 18. No Annual Maximum for Covered Individuals ages 18 and under
Lifetime Maximum Orthodontia Benefit	$2,500
Preventive and Diagnostic Services	No deductible applies
Lifetime Temporomandibular Joint Dysfunction (TMJ) Benefit	$1,500

	THE PLAN PAYS (PPO DENTIST)	YOU PAY (PPO DENTIST)	THE PLAN PAYS (OUT-OF-NETWORK PROVIDER)	YOU PAY (OUT-OF-NETWORK PROVIDER)
Type I Services (diagnostic and preventive)	100% of contracted rate	$0	100% of the UCR Rate	The difference between the UCR Rate and the amount your provider charges
Type II Services (minor restorative)	80% of the contracted rate	20% of the contracted rate; deductible applies	80% of the UCR Rate	20% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Type III Services (major restorative)	70% of the contracted rate	30% of the contracted rate; deductible applies	70% of the UCR Rate	30% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Orthodontia	Benefits are paid, up to the $2,500 Lifetime Maximum benefit, in equal installments while in active treatment every 90 days for up to two years. Medically Necessary services for Covered Individuals age 18 and under are not subject to the Lifetime Maximum.			

GUARDIAN DENTALGUARD PREFERRED SELECT PPO NETWORK

Providers in the Guardian DentalGuard Preferred Select PPO Network have agreed to accept the Plan's contracted rate for covered services as payment in full—you're not responsible for paying the difference between what the provider charges and what the Plan pays.

Finding a Guardian DentalGuard Preferred Select PPO Provider



To find a provider in the Guardian DentalGuard Preferred Select PPO Network, call Guardian at 1-888-600-9200, or use Guardian's on-line provider listing at www.guardianlife.com/service_center/online_provider.html and select the Guardian DentalGuard Preferred Select network

OUT-OF-NETWORK CARE

If you visit a provider that does not participate in the Guardian DentalGuard Preferred Select PPO Network, the Plan will pay for your covered dental expenses based on the UCR Rate. If your provider charges more than this rate, you will be responsible for paying the difference, as well as any coinsurance.

In-Network vs. Out-of-Network

The chart below shows the differences between using an in-network and an out-of-network provider for dental care:

	GUARDIAN DENTALGUARD PREFERRED SELECT PPO NETWORK	OUT-OF-NETWORK
Dentist's charge for a root canal (minor restorative)*	$395	$580
Plan-negotiated amount for service	$330 is the PPO contracted rate	$519 is the UCR Rate
Plan pays 80% after deductible	$264	$415.20
Amount applied toward your annual maximum	$264	$415.20
Amount you pay	20% of the PPO contracted rate—$66	20% of the UCR Rate—$103.80—plus $61—the difference between the actual charges and the UCR amount for a total of $164.80.

**Amount shown in example is for illustrative purposes only. Actual amounts will vary according to your dental care provider.*

DEDUCTIBLE FOR DENTAL SERVICES

A deductible is the amount of Covered Expenses you must pay before any benefits are payable by the Plan. Your annual dental benefit deductible is $50 per person or $100 per family. A new deductible is applied each calendar year (January 1 - December 31). The Plan's dental benefit deductible does not apply to preventive and diagnostic services.

COVERED DENTAL EXPENSES

Covered dental expenses are the services or supplies listed on the following pages that are covered by the Plan. The service or supply must be necessary and given by a Dentist or Physician for the treatment of a Covered Expense.

The maximum amount payable by the Plan for a Covered Expense is limited to $1,875 per Covered Individual age 19 and over per calendar year. When options are available for a particular dental procedure, the Plan will cover the expense of the least costly professionally adequate procedure even if a more costly one is used.

Expenses (excluding Orthodontia) are considered incurred as of the date the service is rendered or the supply is furnished, except:

- with respect to fixed bridgework, crowns, inlays, onlays or gold restorations, the service is considered incurred on the first date of preparation of the tooth or teeth involved;
- with respect to full or partial dentures, the service is considered incurred on the date the impression was taken; and
- with respect to endodontics, the service is considered incurred on the date the tooth was opened for root canal therapy.

Preventive and Diagnostic Services (Type I)

- Cleaning and scaling of teeth (prophylaxis) twice a calendar year.
- Periodontal cleaning of teeth twice a calendar year.
- Emergency treatment (palliative) for dental pain when no other treatment except x-rays are provided.
- Fluoride treatment or application to a dependent Child's teeth once in a calendar year.
- Oral exams twice a calendar year.
- Space maintainers and their fittings.
- X-rays needed to diagnose a dental problem or to check the progress of treatment. Examples of Type I x-rays are:
    - Bitewing x-rays twice a calendar year.
    - Full-Mouth x-rays and panoramic x-rays once every three years to the day.
    - Single tooth (periapical) x-rays.
- Dental sealants are covered once every five years for permanent molars only.

Restorative Services (Type II)

- Cutting procedures in the mouth.
- Extractions or oral surgery.
- Fillings consisting of composite, plastic, porcelain, silicate, or silver (amalgam).
- General anesthesia for oral surgery or treatment of fractures and dislocations.
- Relining or rebasing dentures that are performed at least six months after the denture was originally installed. (Charges for relining or rebasing performed less than six months after the denture was originally installed are usually covered in the cost of the denture.)
- Repairs to bridges, crowns, dentures and inlays that are performed at least six months after the item was originally installed. (Charges for repairs less than six months after the item was originally installed are usually covered in the cost of the item.)
- Root canal work (endodontia).
- Treatment of the gums (periodontia).

Major Services (Type III)

- Adding teeth to fixed bridgework or partial dentures to replace missing natural teeth.
- Dental implants, when necessary, but not more often than once every five years.
- Crowns to repair a tooth that is damaged by decay, injury, or to replace a crown that was installed at least five years before and cannot be repaired.
- Full or partial dentures to replace missing or natural teeth, or when the prior denture was installed at least five years before and cannot be repaired. The maximum covered expense for a permanent denture when replacing a temporary denture is limited to the charge for the permanent denture.
- Inlays to repair a tooth that is damaged by decay, injury, or when the prior inlay was installed at least five years before and cannot be repaired.

Temporomandibular Joint Dysfunction (TMJ)

Benefits are payable for covered Temporomandibular Joint Dysfunction (TMJ) treatment or services. Covered Expenses are those charges made by a Dentist for services or supplies in connection with surgical or non-surgical treatment of TMJ. Surgical treatment of TMJ may also be covered as a medical expense after the TMJ Lifetime Maximum is met. Charges for non-surgical services or supplies in excess of the TMJ Lifetime Maximum are not covered.

Pre-Determination

To assist you in managing your total costs, the Plan offers a predetermination of benefits. Dentists may submit their treatment plan to the Plan for review and an estimate of coverage before procedures are started. The Plan will advise you and your Dentist regarding the services that will be covered and your potential out-of-pocket costs. The actual payment for these pre-determined services depends on eligibility, any Plan limitations, coordination of benefits and the remaining maximum at the time services are performed. A predetermination plan is subject to change based on the Dentist's network participation status at the time of treatment. Once issued, a predetermination plan is valid for 180 days. You are not required to obtain a predetermination plan, but it is strongly recommended for dental services expected to exceed $500.

ORTHODONTIA

Benefits are payable for Orthodontia treatment or services up to an Orthodontia Lifetime Maximum of $2,500 per Covered Individual. Medically Necessary Orthodontia services for Covered Individuals age 18 and under are not subject to the Orthodontia Lifetime Maximum. Precertification is required in order for Orthodontia services to be considered Medically Necessary. Contact the Benefits Office for details.

How Orthodontia Benefits are Paid

Benefits for an entire course of treatment will be paid in equal installments every 90 days. These installments will be made during the course of active treatment or over a two-year period, whichever is less. Benefits are calculated by dividing the Covered Expenses by the number of 90-day treatments. You must be covered on the first day of the 90-day period to receive benefits for that period. The first 90-day period starts on the date an appliance is installed.

Your Orthodontist should send written verification of treatment to the dental claims department every 90 days for the benefit to be paid. Orthodontia benefits will not be made without written verification of active Orthodontia treatment from the Orthodontist.

FILING YOUR DENTAL CLAIMS

You (or your dental care provider) must submit claim forms to:

National Elevator Industry Health Benefit Plan
Dental Claims Department
P.O. Box 475
Newtown Square, PA 19073-0475

WHAT'S NOT COVERED

The following dental services are not covered by the Health Benefit Plan:

- Additional charges for adjustment within six months from installation of a denture or bridge.
- Any service or treatment performed by someone other than a Dentist, Orthodontist, Physician or dental technician under the direct supervision of a Dentist or Physician.
- Any service performed or supply provided to increase the distance between the nose and chin (vertical dimension) or restore occlusion, except for appliances to correct TMJ, other than in connection with the moving of teeth.
- Any service, unless otherwise indicated, not performed to enhance the performance of a natural tooth or covered prosthetic.
- Facings or veneers on molar crowns or molar false teeth.
- Fluoride treatment or application for anyone who is not a dependent Child.
- Mandibular repositioning appliances (orthotics).
- Precision attachments.
- Special techniques that are not considered standard dental treatment.
- Special or non-standard work on a bridge, crown, denture, or inlay.
- Study models for other than Orthodontia service, TMJ services, bridgework and full or partial dentures.
- Tooth bleaching.
- Topical analgesic, as a separate charge when restorative procedures are performed.
- Training or supplies used for dietary counseling, oral hygiene or plaque control.

Other exclusions that may apply to these benefits are listed under the section entitled "What's Not Covered" on page 68.

EXCEPTED BENEFIT STATUS OF DENTAL BENEFITS

A Participant may elect to waive dental benefits coverage under the Plan. To elect to opt out of the Plan's dental benefits coverage, a Participant must notify the Plan in writing. An election not to have dental benefits coverage may be revoked by the Participant at any time by submitting a written request to the Plan. Coverage will resume for covered services rendered on the first of the month after the revocation of the waiver is received by the Benefits Office. You should note, however, that except in the case of Retiree coverage (see page 16), electing to opt out of dental benefit coverage will have no impact on the rate of contributions you or your Employer must make to the Plan or the amount of your self-payment to maintain extended benefits coverage.

Vision Care

Routine eye exams are an important part of your overall health. That's why you and your family members are eligible for annual eye exams at no cost when you visit an EyeMed network provider.

FAST FACTS:

- **You may visit any vision care provider you'd like. Even when you use an out-of-network provider there are no deductibles to meet before the Plan will pay benefits—you receive an allowance toward vision care services.**
- **When you visit a provider in the EyeMed network, an annual routine eye exam costs you nothing.**
- **The Plan provides a one-time only LASIK vision correction surgery benefit for all Covered Individuals.**

You and your eligible dependents age 19 and over are eligible for vision benefits once per calendar year. Children ages 18 and under are not subject to this frequency limit on eye exams. You have the option of visiting any vision care provider you'd like, and you will receive an allowance for services, or you may visit a provider in the EyeMed network to receive even greater discounts.

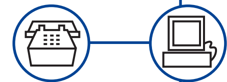
EYEMED VISION BENEFIT

The Plan has a contract with EyeMed, a nationwide provider network made up of Optometrists, ophthalmologists and opticians. Through EyeMed, you and your eligible dependents can receive eye care benefits at a discount.

What You Need To Do:

To find a provider in the EyeMed Network, call 1-877-226-1115 or visit the EyeMed website at www.eyemedvisioncare.com.

- When you make your appointment, identify yourself as a member of the National Elevator Industry Health Benefit Plan.
- At your appointment, present your Plan ID card.



WHAT'S COVERED

Each Covered Individual is entitled to an exam (refractive), frame and lenses or exam (refractive) and contact lenses one time per calendar year. Children ages 18 and under are not subject to this frequency limit.

Also, you and your eligible dependents may take advantage of a one-time only LASIK surgery benefit, described on page 58.

YOUR IN-NETWORK VISION CARE BENEFITS AT-A-GLANCE

VISION BENEFIT	THE MAXIMUM THE PLAN WILL PAY PER CALENDAR YEAR USING THE EYEMED NETWORK
One routine eye exam	Paid in full; no Copayment
Dilation	Paid in full; no Copayment
Lenses* (pair)	Paid in full; $5 Copayment
One pair of eyeglass frames	Up to $110; $5 Copayment
Elective contact lenses*	Up to $65; $5 Copayment
Medically Necessary contact lenses*, prescribed if: ■ Your vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses, or ■ You are being treated for a medical condition and contact lenses are routinely used as part of the treatment.	Up to $315 retail value; $5 Copayment
Progressive lenses	Paid in full; $60 Copayment
Polycarbonate, high index lenses ■ Single ■ Bifocal ■ Trifocal	 Paid in full; $5 Copayment Paid in full; $5 Copayment Paid in full; $5 Copayment
■ UV Coating ■ Tint (Solid and Gradient) ■ Standard Scratch-Resistance ■ Standard Anti-Reflective Coating	Paid in full; $15 Copayment Paid in full; $15 Copayment Paid in full; $15 Copayment Paid in full; $45 Copayment

**If only one lens is necessary, the maximum benefit is one-half the amount of two lenses.*

OUT-OF-NETWORK VISION CARE

The Plan provides an allowance for vision care so that you may visit any provider and still receive a vision benefit. To receive your benefit, simply pay the bill in full at the time of your appointment and submit an itemized bill to the Benefits Office. You will be reimbursed up to the Plan's allowance for each Covered Expense that you incurred.

Filing Your Claims

Send your claim form for covered vision expenses to:

National Elevator Industry Health Benefit Plan
P.O. Box 476
Newtown Square, PA 19073-0476

In some cases, the amount you are charged may be less than the Plan's allowance. The difference will be added to the maximum Covered Expense for any other vision service or supply that you incur within 60 days after the first service or supply.

For Example:
Tom goes to an out-of-network provider for an eye exam. The provider charges him $40. However, the Plan's allowance for an exam is $50. The additional $10 may be added to the allowance for another eye care expense, such as frames or lenses.

YOUR OUT-OF-NETWORK VISION CARE BENEFITS AT-A-GLANCE

VISION BENEFIT	THE MAXIMUM ALLOWANCE THE PLAN WILL PAY PER CALENDAR YEAR OUT-OF-NETWORK
One routine eye exam* ■ Adults ■ Children Age 18 and Under	 ■ $50 ■ No Limit
Lenses** (pair) ■ Single vision ■ Bifocals ■ Trifocals ■ Lenticular	 ■ $55 ■ $90 ■ $100 ■ $140
One pair of eyeglass frames	$50
Elective contact lenses**	$55
UV, anti-scratching, tinting and anti-reflective coatings	$50 (inclusive)
Medically Necessary contact lenses**, prescribed if: ■ Your vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses, or ■ You are being treated for a medical condition and contact lenses are routinely used as part of the treatment.	$315

**Children age 18 and under are not subject to vision care benefit frequency limits.*
***If only one lens is necessary, the maximum benefit is one-half the amount of two lenses.*

VISION BENEFITS FOR RETIREES

Retired Employees who are eligible for vision coverage may select glasses on an annual basis.

WHAT'S NOT COVERED

The following vision care services are not covered by the Health Benefit Plan:
- Non-prescription sunglasses
- Lenses obtained without a prescription
- Safety glasses
- Subnormal vision aids
- Vision training

BENEFITS FOR ONE VISIT PER YEAR

Eyeglass lenses or contact lenses benefits must be used in their entirety during one visit per calendar year (limitation not applicable to Children ages 18 and under).

NO DEDUCTIBLE APPLIES

You do not have to meet a deductible to receive benefits for vision care, including LASIK surgery.

LASIK VISION CORRECTION SURGERY

The Plan provides a one-time benefit for LASIK vision correction eye surgery. The Plan pays 80% of the charge up to a maximum Plan benefit of $1,200 per eye. You are responsible for paying the balance, if any.

For Example:
Chris's LASIK vision correction surgery costs $3,000. The Plan pays 80% up to a maximum of $1,200 per eye, or $2,400. Chris must pay $600.

However, Martin's LASIK vision correction surgery costs $3,500. The Plan pays 80% up to a maximum of $1,200 per eye, or $2,400. Martin is responsible for the $1,100 balance.

You do not have to meet a deductible before the Plan will pay benefits for LASIK Vision Correction Surgery.

U.S. Laser Network

To receive a discount on your LASIK Vision Correction Surgery, contact an LCA-Vision or LasikPlus center near you. These network centers are affiliated with the U.S. Laser Network, a program offered to Plan members through the EyeMed Vision Care program.

To find a network center near you or a participating laser vision provider, call 1-877-NEILASER (1-877-634-5273). You can also visit EyeMed's website for more information on laser vision surgery at www.eyemedvisioncare.com.

Other exclusions that may apply to these benefits are listed under the section entitled "What's Not Covered" on page 68.

Fundus Photography/Retinal Imaging

Coverage is provided for Fundus Photography/Retinal Imaging which involves the use of a retinal camera (ophthalmoscope) to photograph the regions of the vitreous, retina, choroid and optic nerve. The digital photos are typically taken through a dilated pupil to document the presence or progression of a variety of eye diseases, such as, glaucoma, macular degeneration, diabetic retinopathy, retinal tears and multiple sclerosis.

Fundus Photography/Retinal Imaging will be paid in full, no co-pay, for an in-network EyeMed provider. An out-of-network vision provider will be paid at 100% up to the UCR Rate. Fundus Photography/Retinal Imaging will be a Covered Expense no more frequently than once per calendar year.

Excepted Benefit Status of Vision Benefits

A Participant may elect to waive vision benefits coverage under the Plan. To elect to opt out of vision benefits coverage, the Participant must notify the Plan in writing. An election not to have vision benefits coverage may be revoked by the Participant at any time by submitting a written request to the Plan. Coverage will resume for covered services rendered on the first of the month after the revocation of the waiver is received by the Benefits Office. You should note, however, that except in the case of Retiree coverage (see page 16), electing to opt out of vision benefit coverage will have no impact on the rate of contributions you or your Employer must make to the Plan or the amount of your self-payment to maintain extended benefits coverage.

Hearing Care

The Plan pays benefits related to hearing care, including exams and hearing aids. Benefits are payable for covered services and supplies if they are prescribed by a duly qualified Physician and if they are needed to restore hearing loss or treat impaired hearing.

FAST FACTS:

- **The Plan's Hearing Care Program is administered by AudioNet America. You must call AudioNet at 855-800-7147 to access Hearing Care Program benefits under the Plan.**
- **The Plan will pay for a hearing aid for each ear once every 36 months for covered adults and once every 12 months for dependent Children under age 19.**
- **The Plan's Hearing Care Program includes a 36 month supply of batteries for your hearing aid(s). One pack of 8 batteries (per ear) will be provided at the time of dispensing; thereafter, AudioNet will mail replacement batteries directly to your home.**
- **You do not have to meet a deductible for your Hearing Care Program benefits.**
- **You must use an AudioNet provider, and Hearing Care Program services are covered on a pre-authorized basis only.**
- **If you reside more than 25 miles from an in-network provider, you must contact AudioNet directly for assistance before obtaining services or equipment out-of-network.**
- **You will not be balance billed for covered services and equipment obtained through an AudioNet provider.**

HEARING CARE BENEFITS

The Plan's Hearing Care Benefits are administered exclusively through AudioNet.

What You Need To Do:

- When you or one of your eligible dependents requires hearing care services, you must call AudioNet America at 855-800-7147. AudioNet will assist you in finding a participating provider specific to your needs.
- You will need to contact the provider directly and schedule a convenient appointment time. Identify yourself as a National Elevator Industry Health Benefit Plan Participant with AudioNet coverage. The provider's office will contact AudioNet directly and obtain pre-authorization.
- The provider will file the claim with AudioNet. You will not be balance billed.

WHAT'S COVERED

Testing. The Plan covers one hearing exam as well as a hearing evaluation (per ear) once every 36 months for adults and once every 12 months for dependent Children under age 19. The Plan also covers, in full, hearing aid conformity evaluations after dispensing. There are no deductibles and you will not be balance billed.

Hearing Aids. The Plan covers, in full, various manufacturer's types and models of hearing aids once every 36 months for adults and once every 12 months for dependent Children under age 19. You and your Physician can review a complete list of hearing aids online at www.audionetamerica.com. There are no deductibles and you will not be balance billed. Hearing aids obtained through AudioNet providers also include a 2-year repair warranty and 2-year loss and damage coverage. The 2-year loss and damage coverage allows for a one-time replacement of a lost or irreparably damaged hearing aid.

Dispensing Fees. The Plan covers, in full, dispensing fees relating to hearing aid(s) once every 36 months for adults and once every 12 months for dependent Children under age 19.

Office Visits. The Plan covers, in full, follow-up office visits relating to hearing aid maintenance/fittings during the first 6 months after you receive your hearing aid.

Batteries. The Plan covers a 36-month supply of batteries for your prescribed hearing aid(s). One pack of 8 batteries (per ear) will be provided at the time of dispensing. AudioNet will ship your first year's supply of 48 batteries soon after you receive your hearing aid(s). A second year's supply of 48 batteries will be shipped automatically upon the dispensing date anniversary with a third year's supply of 48 batteries being shipped upon the second dispensing date anniversary.

Replacement Ear Molds (Children under Age 8 Only). The Plan will cover, in full, up to 4 replacement ear molds (per ear) per 12-month period for Children up to age 3. The Plan will cover, in full, up to 2 replacement ear molds (per ear) per 12-month period for Children ages 3 to 7. While the cost of your first hearing aid ear mold is a covered Hearing Care Program benefit, the Plan does not cover replacement ear molds for Covered Individuals age 8 or older.

Out-of-Area Hearing Care Benefits. If you reside more than 25 miles from an in-network provider, you must contact AudioNet directly for assistance before obtaining services or equipment out-of-network. If, after consulting with AudioNet, it is determined that it is unreasonable for you to obtain covered services or equipment through an AudioNet provider, the Plan will cover out-of-network hearing care services and equipment that would otherwise be covered under the Plan's Hearing Care Program if obtained through an AudioNet provider as follows:

- 100% of the cost of all covered services and/or equipment up to a combined maximum of $2,000 per ear per 36 months for adults;
- 100% of the cost of all covered services and/or equipment up to a combined maximum of $2,000 per ear per 12 months for Children under age 19.

You are responsible for any costs in excess of these maximums.

WHAT'S NOT COVERED

Other exclusions that may apply to the Plan's Hearing Care Program benefits are listed under the section entitled "What's Not Covered" on page 68 of the Summary Plan Description.

The following services and equipment are not covered under the Plan's Hearing Care Benefit:

- Except as described above in "Out-of-Area Hearing Care Benefits," services and equipment not obtained through an AudioNet provider. If you reside more than 25 miles from an in-network provider you should contact AudioNet directly for assistance.
- Replacement ear molds (except for Children under age 8) or earplugs. However, AudioNet has negotiated special pricing for replacements within the network.
- Any retail items associated with hearing aids including, but not limited to, remotes or beepers to locate your device.
- Audiometric examinations for any condition other than loss of hearing acuity.
- Medical or surgical treatment, drugs or other medications. However, please review other relevant sections of the Summary Plan Description or contact the Benefits Office to determine whether such medical or surgical treatment, drugs or other medications may otherwise be covered under the Plan.
- Hearing aids ordered while covered but delivered more than 60 days after termination of coverage.
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not Medically Necessary and, in the case of an initial hearing aid or any hearing aid for a person under age 19, charges for hearing aid evaluation tests or hearing aids that are not recommended or approved by the audiologist or Physician. (For purposes of the Plan's Hearing Care Program, a "Physician" is a participating otologist or otolaryngologist or otorhinolaryngologist who is board certified or eligible for certification in such specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of such license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid.)
- Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the Plan's negotiated maximum rate with AudioNet for one hearing aid.
- Charges for failure to keep a scheduled visit with a provider.
- Charges for hearing care benefits not expressly identified above.

Weekly Income Benefit (Active Members Only)

If you become totally disabled and cannot work, the Plan provides a weekly payment to you for up to 26 weeks.

FAST FACTS:

- **You may receive a weekly income benefit during your total disability as long as you are under the care of a Physician.**
- **Benefits are payable when the Plan receives written proof that you are totally disabled due to an injury, Illness, or pregnancy and require the active care of a duly licensed Physician.**

YOUR WEEKLY INCOME BENEFIT AT-A-GLANCE

Weekly Income Benefit	$500 (May be different in NY, NJ and HI)
Maximum Payment Period	26 weeks
Waiting Period-Injury	0 days
Waiting Period-Illness	7 days

What You Need To Do:

- When you become totally disabled you should contact the Benefits Office for a claim form.
- You are required to provide proof of your total disability from a duly licensed Physician.
- Submit your claim form and proof to:
  National Elevator Industry Health Benefit Plan
  P.O. Box 476
  Newtown Square, PA 19073-0476

After you've satisfied the applicable waiting period, you will begin receiving your benefit.

WHAT'S THE PLAN'S DEFINITION OF "TOTAL DISABILITY"

For purposes of weekly income benefit eligibility, the Plan defines total disability as your complete inability to perform any and every duty pertaining to an occupation or employment.

The Plan will pay the weekly income benefit to you after you've satisfied the appropriate waiting period. If benefits are payable for less than a full week, the benefit payable will be one-seventh of the weekly benefit for each day it is due.

On a periodic basis, the Plan will require current information to support your claim for weekly income benefits. Your attending Physician must certify that you remain totally disabled in order for you to continue to receive weekly income benefits.

Periods of Disability

You may receive the weekly income benefit for up to 26 weeks per period of total disability. You must return to work on a full-time basis for at least one week to start a new period of total disability unless the total disability is due to a separate and unrelated injury, Illness, or pregnancy and begins after you return to work on a full-time basis.

When Your Benefit Ends

The weekly income benefit will stop when any of the following occurs:

- You return to covered employment in the position you were in when you became totally disabled;
- The maximum payment period has been paid;
- Your total disability ends;
- You begin receiving a monthly Disability Retirement Pension Benefit or other pension benefit under the NEI Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan. All weekly income benefits you receive that cover periods in which you receive a pension benefit under these pension plans must be refunded in full to the Plan.
- You are no longer under the active care of a duly licensed Physician or a preferred provider or facility; or
- You die.

Filing a Claim

For claims and appeals procedures, see page 73.

WHAT'S NOT COVERED

You are not eligible to receive weekly income benefits if your disability commenced on or after the date of your termination or suspension of covered employment or if your disability is due to:

- an injury or Illness that happens or is the result of work at any job for pay or profit.
- an injury or Illness for which payment is made through any workers' compensation or similar law.
- war, declared or undeclared, or any act of war.
- intentionally self-inflicted injury.
- an injury or Illness arising from the active participation in a riot.

Other exclusions that may apply to these benefits are listed under the section entitled "What's Not Covered" on page 68.

Life Insurance

You want your family to be protected in case something happens to you. The Health Benefit Plan, through its insurance policy with the Amalgamated Life Insurance Company, provides a life insurance benefit of $40,000, payable to your beneficiary, in the event of your death. Eligibility for life insurance benefits is determined in accordance with the Plan's eligibility rules.

FAST FACTS:

- **To change your beneficiary, contact the Benefits Office for an enrollment form. The enrollment form must be dated, signed and notarized and on file with the Benefits Office at the time of your death to be valid. In addition, Disability Retirees in receipt of a Disability Pension from the NEI Pension Plan may designate their beneficiary on a pension application (Disability Retirees in receipt of a Disability Pension from the IUEC Officers and Employees Pension Plan should contact the Benefits Office for an enrollment form.)**
- **The life insurance benefit is only payable on behalf of eligible Active Members and on behalf of eligible Disability Retirees in receipt of a Disability Pension from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan (who are under age 65).**
- **You have the right to convert your life insurance to an individual policy if you leave covered employment.**

KEEP YOUR BENEFICIARY DESIGNATION UP-TO-DATE

If you'd like to change your beneficiary designation, contact the Benefits Office or visit www.neibenefits.org for an enrollment form. The designation will not be effective until the Benefits Office receives your signed, dated and notarized enrollment form. Remember, a divorce voids your designation of your ex-Spouse as beneficiary.

The beneficiary (or beneficiaries) of eligible Active Members or eligible Disability Retirees will receive through the Plan's insurance carrier a total life insurance benefit of $40,000 upon the Active Member's or Disability Retiree's death.

Eligibility for a Life Insurance Benefit

Your beneficiary is eligible for a life insurance benefit at the time of your death if you were:

- an eligible Active Member (Benefits Office Employees are not eligible for the life insurance benefit);
- an eligible Disability Retiree under age 65 in receipt of a Disability Pension from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan.

What Your Beneficiary Needs to Do:

- If you die, your beneficiary should contact the Benefits Office at 1-800-523-4702 for a life insurance claim form.
- Your beneficiary should submit a claim for life insurance benefits to:
  National Elevator Industry Health Benefit Plan
  19 Campus Blvd., Suite 200
  Newtown Square, PA 19073
  Attn.: Life Insurance Claims Department

Your Beneficiary

You may name anyone you'd like to be your beneficiary(ies) for your life insurance benefit. However, this designation must be on file at the Benefits Office at the time of your death in order to be valid. To change a beneficiary designation you must complete an enrollment form, available from the Benefits Office or the Benefits Office website—www.neibenefits.org. Your enrollment form must be signed, dated and notarized. In addition, a Disability Retiree of the National Elevator Industry Pension Plan may designate his or her beneficiary on a pension application. If there is no beneficiary(ies) on file, or your beneficiary(ies) predeceases you, your life insurance benefit will be paid to your estate. **A divorce will automatically void the designation of your ex-Spouse as your beneficiary. If after a divorce you want to designate your former Spouse as beneficiary, you must complete a new enrollment form and submit it to the Benefits Office.**

Extended Life Insurance If You're Totally Disabled

Your life insurance coverage will remain in force if you become totally disabled and die:

- before you reach age 65;
- before you begin to receive a pension benefit from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan other than a Disability Pension; and
- after 31 days but within a year of the date your life insurance would have terminated because you ceased to be an Active Member.

Proof of your total disability must be submitted to the Benefits Office within nine months of your disability onset date confirming that you were totally disabled from the date you last worked in covered employment until the date of your death.

HOW DOES THE PLAN DEFINE "TOTALLY DISABLED"?

For purposes of the Plan's Life Insurance Benefit, "totally disabled" is defined by the Plan's life insurance carrier as the incapacity of the insured resulting from injury or disease, to engage in any occupation for remuneration or profit.

CONVERTING YOUR LIFE INSURANCE

If your life insurance coverage ends because you stop working in covered employment, you may convert your group life insurance without a medical examination or other evidence of insurability to any individual life insurance policy issued by Amalgamated (other than term insurance). To convert your life insurance coverage, apply to Amalgamated within 31 days after your insurance terminates or, if later, 15 days after you receive notice of your right to convert, and pay the required premiums. The amount of your individual policy may not be more than $40,000, minus any amount you become eligible for under any other group plan within 31 days if you become employed and are eligible for life insurance through Amalgamated.

If your insurance is terminated due to an amendment or because the Plan decides to discontinue the group policy, you will have the same conversion privileges described above as long as you have been insured under this group policy for at least five years. The amount of your individual policy may not be more than the lesser of:

- $40,000 reduced by the amount of insurance you have from any other carrier; or
- $10,000.

Your group life insurance is payable by the Plan if you die within the 31-day period allowed for conversion, even if you have not applied for an individual policy.

WHAT'S NOT COVERED

Aviation other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Accidental Death and Dismemberment Insurance

If you become injured and suffer a loss due to an accident, you (or in the case of your death, your beneficiary) may be eligible to receive a lump-sum payment through the Plan's accidental death and dismemberment (AD&D) benefit. Like its life insurance benefit, the Plan's AD&D benefit is provided through the Plan's insurance policy with the Amalgamated Life Insurance Company.

FAST FACTS:

- **The AD&D benefit generally is payable if your loss is a direct result of an injury caused by an accident.**
- **This benefit is only available for eligible Active Members (excluding Benefits Office Employees) and eligible Disability Retirees in receipt of a Disability Pension from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan who are under age 65 (dependents and other Retirees are not covered under the AD&D benefit).**
- **The AD&D benefit is payable in addition to and separate from the Plan's life insurance benefit.**

YOUR AD&D BENEFITS AT A GLANCE

LOSS	BENEFIT
Life	$40.000
Both hands/arms or both feet/legs	$40,000
Sight of both eyes	$40,000
Speech and Hearing	$40,000
Any combination of one foot, one hand, Sight in one eye, Speech, Hearing	$40,000
One arm or one leg	$30,000
One hand, or one foot, or Sight in one eye, or Speech, or Hearing	$20,000

Loss means:
- Severance of hand or foot at or above the wrist or ankle joint;
- The total and irrecoverable loss of sight;
- Total and irrecoverable loss of audible speech communication;
- Total deafness in both ears, which cannot be corrected to any functional degree by any aid or device;
- Severance of arm or leg at or above the elbow or knee

PARALYSIS OR COMA	BENEFIT
Quadriplegia (complete and irreversible paralysis of both upper and both lower limbs	$40,000
Paraplegia (complete and irreversible paralysis of both lower limbs)	$30,000
Hemiplegia (complete and irreversible paralysis of the upper and lower limbs on one side of the body)	$20,000
Uniplegia (total paralysis of one limb)	$10,000
Coma $800	

The AD&D benefit is payable to you if you suffer any of the losses or paralyses listed above or you lapse into a coma within 90 days of an injury that occurred as a direct result of an accident while you are an Active Member or eligible Disability Retiree. The maximum AD&D benefit payable for all injuries resulting from one accident will not exceed $40,000, except as follows:

- If an Active Member dies as the result of accidental injury that occurs while the Active Member is performing the usual and customary duties of his/her occupation, an additional benefit of $40,000 will be paid to the Active Member's beneficiary.
- If an Active Member dies as a result of an accidental injury that occurs while riding as a passenger in or on a common carrier, an additional benefit of $40,000 will be paid to the Active Member's beneficiary. (A "common carrier" is any air, land or water vehicle operated for regular passenger service on regular defined routes between established points of arrival and departure).

AD&D benefits are payable to your designated beneficiary if you die due to an accident that occurs while you're covered under this benefit. This benefit is payable in addition to the life insurance benefit.

The AD&D benefit is provided by Amalgamated. Amalgamated is solely responsible for determining if a loss is caused by an accident as defined in this Plan's insurance policy with Amalgamated. Appeals to the Trustees on issues related to whether the loss is covered by the AD&D policy will be forwarded to Amalgamated for final decision.

ELIGIBILITY FOR AN AD&D BENEFIT

An AD&D benefit will be paid for an accidental death or dismemberment resulting from accidental bodily injury and incurred while you are:

- an eligible Active Member (Benefits Office Employees are not eligible for AD&D benefits); or
- an eligible Disability Retiree in receipt of a Disability Pension from the National Elevator Industry Pension Plan or the IUEC Officers and Employees Pension Plan who is under age 65.

What You (or Your Beneficiary) Need to Do:

- Contact the Benefits Office for an AD&D claim form.
- Submit the claim form to:

  National Elevator Industry Health Benefit Plan
  19 Campus Blvd., Suite 200
  Newtown Square, PA 19073
  Attn: AD&D Claims Department

Your Beneficiary

You may name anyone you'd like to be your beneficiary for your AD&D benefits in the event of your accidental death. However, this designation must be on file at the Benefits Office at the time of your death in order to be valid. To change your beneficiary, you must complete an enrollment form, available from the Benefits Office or the Benefits Office website www.neibenefits.org. Your enrollment form must be signed, dated and notarized. In addition, a NEI Pension Plan Disability Pension Retiree may designate his or her beneficiary on a pension application. If there is no beneficiary on file, or if your beneficiary predeceases you, your AD&D benefit will be paid to your estate in the event of your death. **A divorce will automatically void the designation of your ex-Spouse as your beneficiary. If you want to designate your former Spouse as beneficiary, you must complete a new enrollment form and submit it to the Benefits Office.**

WHAT'S NOT COVERED

No AD&D benefit will be paid for losses resulting from or caused directly or indirectly by:

- War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion.
- Sickness, disease or bodily infirmity (not including bacterial infection which results from an accidental cut or would or accidental ingestion of a poisonous food substance).
- Intentionally self inflicted injury, while sane or insane.
- Suicide or attempted suicide, while sane or insane.
- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers.
- Commission of or participation in a crime.

The insurance company providing the AD&D coverage to this Plan is the sole and only decision-maker on issues arising under any of the above.

Member Audit Savings Program

If you discover a billing error from any service provider and have it corrected, you might be entitled to a reward from the Plan. The reward is 50% of the savings to the Plan, to a maximum reward of $500. The amount corrected must be a minimum of $100. The provider, as a result of your discovery, must send a corrected bill, and, if applicable, a refund to the Benefits Office Claims Department before the reward will be sent.

What's Not Covered

In addition to the specific information listed in each section, expenses for the following services are not covered under the National Elevator Industry Health Benefit Plan:

- Expenses for any service or supply that is not Medically Necessary. (See Glossary of Terms page 90)
- Expenses for any service not listed as a Covered Expense.
- Expenses for court costs and/or legal fees except as provided under the Plan's Member Assistance Program.
- Expenses for treatment or services for a person who is not covered by the Plan or was not covered at the time the treatment/service was performed.
- Expenses for Custodial Care.
- Expenses for early intervention services.
- Expenses for education or training, except as otherwise listed in this Summary Plan Description.
- Expenses for services that are paid for by another welfare benefit plan or other group plan.
- Expenses for which a claim is not received by the end of the second calendar year following the calendar year in which the expense occurred.
- Expenses resulting from an injury or Illness sustained while you were performing any occupation or employment for remuneration or profit.
- Expenses incurred by the donor or recipient related to the assisted reproduction, maternity care and delivery associated with a surrogate mother's pregnancy.
- Expenses that you are not obligated to pay.
- Experimental treatments or investigational services.
- Expenses for injury or Illness caused by war or intentional armed conflict.
- Expenses for interest.
- Expenses for late charges and/or collection fees of any type.
- Expenses for photos.
- Expenses for services performed by a provider whose credentials are not recognized by the Plan, including, but not limited to an O.M.D, A.C.R., A.T., C.D., C.L.C., C.M.T., C.N.T., C.P.M., C.S.C.S., L.M.T., M.A., N.D., acupuncture or acupressure providers not certified by the National Certification Commission for Acupuncture and Oriental Medicine, and P.T.A.
- Expenses for surface EMGs.
- Expenses for treatment by a Physician that is not within the scope of his or her license.
- Expenses for treatment not ordered by a Physician.
- Care or treatment to the teeth and gums, when not paid under the Plan's Dental Benefits section, except for the following:
  - Cutting procedures on the gums, up to the UCR Rate;
  - Oral surgery to remove an impacted tooth, up to the UCR Rate; or
  - First repair and/or restoration to Sound Dentition as the sole result of a covered injury by an external, unexpected and violent accident. Sound Dentition is defined as a healthy tooth (stable, functional, free from decay and periodontal disease) or one that has been restored to a sound condition or replacement by a fixed or removable partial denture, crown or bridge. Treatment must be provided within twelve months of the accident date. Injury during chewing or biting is not considered accidental.
- Charges resulting directly or indirectly from the commission of a felony.
- Charges incurred for the treatment of a Cosmetic condition.
- Charges in excess of the UCR Rate for services provided by a non-PPO provider.
- Charges that are not Medically Necessary for the care or treatment of an injury, Illness or pregnancy (unless otherwise stated).
- Dental work, except as otherwise listed as a Covered Expense under the Plan's Dental Benefits section.
- Eye exam for glasses, except as otherwise listed as a Covered Expense under the Plan's Vision Benefits section.
- Eyeglasses and refraction because of a covered injury that is not paid under the Plan's Vision Benefits section.
- Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as payable under the Genetic Testing heading under "Your Medical Benefits."
- Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization.
- Genetic testing performed primarily for the medical management of individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-Covered Individual only if such testing would directly impact the treatment of a Covered Individual.
- Genetic testing determined to be not Medically Necessary, Experimental or investigational.
- Home genetic testing kits and services.
- Medical care or treatment not recommended by a duly qualified Physician.
- Neurodiagnostic and electrodiagnostic testing not performed by a certified neurologist.
- Nutritional supplements.
- Prescription drugs, except as otherwise listed under the Plan's Prescription Drug Benefits section.
- Radial keratotomy.
- Replacement of batteries or cords except as provided under the Plan's hearing care benefit.
- Services of a pastoral counselor in the course of his/her normal duties, except as provided under the Plan's Hospice Care section.
- Services of a psychiatrist or Psychologist unless provided under the Plan's Substance Abuse/Mental Health Benefits section.
- Services provided by volunteers or individuals who do not normally charge for their services.
- Visits for consultation with a specialist after the first two visits.
- Weight loss programs of any type.

Coordination of Benefits

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

FAST FACTS:

- **You must report any duplicate group health coverage for yourself and/or your dependents on any claim you submit to the Benefits Office.**
- **Benefits under this Plan are coordinated with HMO, PPO, Medicare or other group health care coverage.**

Coordination of Benefits is when the health benefits payable under the National Elevator Industry Health Benefit Plan are coordinated with the benefits payable by any other plan. The benefits payable under this Plan may be reduced so that your benefits from all plans do not exceed 100% of the total allowable expense under this Plan.

As related to Coordination of Benefits, the term "any other plan" includes, but is not limited to:

- Another health plan,
- Medical payments coverage under a residential or commercial insurance policy or plan,
- No-fault, Personal Injury Protection (PIP) or medical payments coverage under an automobile policy or plan.

When this Plan is primary, it will pay first and benefits provided by this Plan will not be reduced by benefits payable by another plan.

When this Plan is secondary, benefits payable under the Plan may be reduced by benefits payable under any plan that is primary to this Plan. When this Plan is secondary, the standard method of coordinating benefits is used. This means that the amount payable under the Primary Plan will be subtracted from the Plan's total allowable expense and the Plan will pay the difference, if any, minus any applicable deductible.

When both Spouses work in the elevator industry, the Plan's payment as secondary payer will equal the unpaid covered portion of the Plan's total allowable expense.

The following rules are used to determine which plan is primary and which plan is secondary (applied in the sequence listed below):

- With respect to auto no-fault, PIP or medical payments coverage, this Plan will always be secondary and any auto no-fault, PIP or medical payments coverage will be primary, regardless of any election or designation to the contrary.
- The plan that does not have a Coordination of Benefits provision is primary to the plan that has a Coordination of Benefits provision.
- The plan that covers the individual as an employee is primary to the plan that covers the same individual as a dependent.
- The plan that covers the individual as an active employee is primary to the plan that covers the individual as a retiree or dependent of a retiree.
- The plan that covers a person as a dependent of the parent whose birthday is earlier in the calendar year is primary to the plan that covers the individual as a dependent of the parent whose birthday is later in the calendar year. If both parents have the same birthday, the plan that has covered one of the parents longer will be primary to the plan that covers the other parent. If the other plan does not have a rule based on birthdays similar to this one, the other plan will be primary to this Plan.

However, when the Covered Individual is a dependent Child under two or more plans of divorced or separated parents, the following rules apply unless a Qualified Medical Child Support Order provides otherwise:

- The plan of the parent with custody will be primary to the plan of the parent without custody.
- If the parent with custody remarries, the plan of the parent with custody will pay first, the plan of the step-parent with custody will pay next and the plan of the parent without custody will pay last.
- When a court decree exists which has specific terms giving one parent financial responsibility for certain health expenses of a dependent Child, the plan which covers the parent as an employee is primary to any other plan covering the dependent Child.
- If none of the above rules apply, the plan covering the individual for the longest time is primary. To determine the length of time an individual has been covered under a plan, two successive plans shall be treated as one if the Covered Individual was eligible under the second plan within 24 hours after coverage under the first plan ended. The individual's length of time covered under a plan is measured from the individual's first date of coverage under that plan, but if that date is not readily available for a group plan, the date the individual first became a member of the group shall be used as the date from which to determine the length of time the individual's coverage under the present plan has been in force.

For Example:
Brian Constructor's wife, Sara, is also employed and has her primary coverage with her employer's group health plan. Assume that Sara has expenses of $1,000 for which this Plan's usual benefit is $780. In addition, assume that Sara's employer's group plan, her primary coverage, has paid its benefit of $650. This Plan, as Secondary Payer, using the standard method of coordinating benefits, would pay $130. (Other plan payment at $650 plus the NEI Plan's payment of $130 equals $780 the amount this Plan would have paid if there were no other payer.)

COORDINATION WITH MEDICARE

When you or your Spouse reach age 65, or you or one of your eligible dependents become totally disabled, you or your dependents may be eligible for Medicare. Therefore, you and/or your dependent must enroll in Medicare as soon as you are eligible for Parts A and B. (See page 31.)

All expenses that may be covered by this Plan should first be submitted to Medicare. No payment will be made by this Plan for any charge you are not liable to pay.

Medicare is the Primary Plan for the following individuals:
- Retirees age 65 and older and their dependents age 65 and older;
- Medicare-disabled former Employees or Retirees under age 65; and
- Medicare-disabled dependents of former Employees or Retirees.

Medicare is the Secondary Plan for the following individuals:
- Disabled Active Members; and
- Disabled dependents of Active Members.

If Medicare Part A Coverage is Not Free

If you are a Retiree (or an eligible dependent of a Retiree) who is eligible for Medicare because of your age, but you're ineligible for free Medicare Part A hospital coverage, this Plan will be your Primary Plan. You must otherwise be eligible for Plan benefits, but you are not eligible for Medicare Part A coverage because of your own work record or the work record of a Spouse or parent ("piggyback" coverage).

Social Security must send a letter to the Benefits Office indicating that free Medicare Part A coverage is not available to you before this Plan can pay otherwise covered health claims.
The letter should be sent to: NEI Health Benefit Plan, c/o Director, Health Claims Administration, 19 Campus Blvd., Suite 200, Newtown Square, PA 19073.

Active Members Age 65 or Older

The National Elevator Industry Health Benefit Plan is the Primary Plan for you and your family including a family member who qualifies for Medicare because of age or total disability. If you are an Active Member age 65 or older and your dependents are not eligible for Medicare, you will receive the same medical benefits as Active Members under age 65 and their eligible dependents. You must enroll for Medicare Parts A & B as soon as you are eligible if you want Medicare to be the secondary payer. Failure to enroll in Medicare as soon as you are eligible may result in a delay in Medicare coverage at a later date.

OTHER PARTY LIABILITY CLAIMS

The Plan's Right of Recovery

The Plan has the right to recover benefits advanced by the Plan to a Covered Individual for expenses or losses caused by another party. If a Covered Individual is injured or becomes ill under circumstances where another party is directly or indirectly responsible for the Illness or injury, the Plan is only obligated to provide Covered Expenses resulting from that Illness or injury that exceed any amounts recovered from another party (whether or not the amount recovered is designated to cover medical expenses).

Amounts that have been recovered by a Covered Individual from another party are assets of the Plan by virtue of the Plan's subrogation interest and are not distributable to any person or entity without the Plan's written release of its subrogation interest. However, amounts recovered by such Covered Individual from another party in excess of benefits paid by the Plan are the separate property of such Covered Individual. Unless otherwise provided in this Summary Plan Description, amounts received from an individual health insurance policy for which the injured Covered Individual or other family member has paid premiums are also the separate property of the Covered Individual.

Amounts received from a personal homeowner’s insurance policy, an automobile insurance policy or a group insurance arrangement of any kind, regardless of whether the injured Covered Individual or other family member has paid premiums, are considered a payment from another party and are subject to the Plan's right of recovery hereunder.

The Plan's right of recovery also applies if benefits are advanced by the Plan to an individual acting on behalf of an injured Covered Individual or to the Covered Individual's assignee.

The Plan's Right of Reimbursement

The Plan has a right to first reimbursement out of any recovery. Acceptance of benefits from the Plan for an injury or Illness by a Covered Individual, without any further action by the Plan and/or the Covered Individual, constitutes an agreement that any amounts recovered from another party by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, will promptly be applied first to reimburse the Plan in full for benefits advanced by the Plan due to the injury or Illness and without reduction for attorneys' fees, costs, expenses or damages claimed by the Covered Individual, and regardless of whether the Covered Individual is made whole or recovers only part of his/her damages.

Acceptance of benefits from the Plan for an Illness or injury by a Covered Individual constitutes the Covered Individual's agreement to file a claim for benefits against any party who may be liable for the injury or Illness to the Covered Individual and to file claims under any and all applicable policies of insurance or self-insurance, including but not limited to homeowner’s insurance, auto insurance, or any liability policy held for a public or commercial entity. The Covered Individual must promptly file a claim for damages against any party who may be liable and any such applicable policy and notify the Plan of his/her claim against such parties or policies or other recovery efforts. The Covered Individual agrees that neither he/she nor anyone acting on his/her behalf will settle any claim relating to the injury or Illness without the written consent of the Plan. The Plan reserves the right to make all decisions with respect to its rights of subrogation and recovery.

Acceptance of benefits from the Plan for an Illness or injury by a Covered Individual constitutes the Covered Individual's agreement to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against another party, including, if requested by the Plan, the institution of a legal proceeding against another party or any insurer or recipient of Plan assets improperly distributed without the written consent of the Plan.

Acceptance of benefits from the Plan for an Illness or injury by a Covered Individual constitutes authorization for the Plan to sue, compromise or settle, in the Covered Individual's name or otherwise, all rights, claims, interests or causes of action to the extent of benefits advanced.

Acknowledgement Form

Prior to advancement of a benefit by the Plan to a Covered Individual for any expense or loss for which there may be a claim against another party, a Covered Individual must execute a written document acknowledging the Plan's right of recovery as set forth in this section and must provide information including the expense or loss for which another party may be liable and insurance coverage.

Failure to Execute Acknowledgement Form

Even if no Acknowledgement Form is sent by the Plan or sent but not signed, based solely upon the Plan's advancement of benefits, the Plan has a subrogation and reimbursement interest in the amount recovered, or to be recovered, by the Covered Individual for the entire amount advanced by the Plan for the claim, even if the Covered Individual does not execute the Acknowledgement Form. The Covered Individual must promptly notify the Plan of any recovery from any source.

Claimant's Failure to Reimburse

Should it be necessary for the Plan to institute legal action against the Covered Individual for failure to return Plan assets, in full, or to honor the Plan's interest in the amount recovered by the Covered Individual from another party, the Plan may bring suit against the Covered Individual and such Covered Individual is liable for all of the Plan's costs of collection, including reasonable attorneys' fees and costs.

Right to Withhold Future Benefits

The Plan has the right to treat any benefits provided as an advance and to deduct such amounts from future benefits to which the Covered Individual or an immediate covered family member may otherwise be entitled until the amount due the Plan has been satisfied. Such amounts may be deducted from amounts due to third party medical providers despite any certification of Plan coverage that may have been provided to these providers.

Failure to Notify the Plan of Possible Other Party Liability

The Plan has all rights specified in this section in the event that a Covered Individual fails to inform the Plan that another party may be liable for the Covered Individual's Illness or injury and the Plan pays any benefits arising from that Illness or injury.

Definition of “Party”

For purposes of this section "party" is defined to include, but is not limited to, any of the following:

- The party or parties that caused the Illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who cause the Illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the Illness, sickness or bodily injury;
- A workers’ compensation insurer; and/or
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness, sickness or bodily injury.

Filing Your Claims

In general, when you use an in-network provider, the provider will file your claims for you. In all other cases, you must submit your claims either to your local Blue Cross Blue Shield Plan or the Benefits Office, as applicable. Refer to chart below for the appropriate address.

BCBS Medical (except Medicare Primary claims)	Your Local BCBS Plan
Medicare Secondary Claims	National Elevator Industry Health Benefit Plan P.O. Box 910 Newtown Square, PA 19073-0910
Non-BCBS Medical Claims	National Elevator Industry Health Benefit Plan P.O. Box 477 Newtown Square, PA 19073-0477
Dental Claims	National Elevator Industry Health Benefit Plan P.O. Box 475 Newtown Square, PA 19073-0475
Weekly Income Benefit and Non-EyeMed Vision Claims	National Elevator Industry Health Benefit Plan P.O. Box 476 Newtown Square, PA 19073-0476
Life Insurance Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn.: Life Insurance Claims Department
Accidental Death and Dismemberment Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn.: AD&D Claims Department

Claim forms and documentation must be sent to the Benefits Office no later than 90 days after you have received medical service. Not furnishing proof within this period will not invalidate or reduce your claim if you can show that, although late, proof was furnished as soon as was reasonably possible.

A claim will be deemed incomplete if you do not provide enough information for the Benefits Office to determine whether and to what extent your claim is covered by the Plan.

The Benefits Office has the right to request additional medical opinions for you and your eligible dependents when and as often as it may reasonably be required when a claim is pending.

The Benefits Office has the right to require the provider's statement of the treatment and to request from the provider models, pre- and post-operative x-rays, and any such additional evidence it deems necessary to determine whether a claim is eligible for payment under the Plan.

All benefits will be paid after receipt of the claim form and documentation, except that:

- Upon your request and subject to documentation of your eligibility for such benefits, Weekly Income Benefits will be paid each week during any period for which benefits are provided as described on page 7 and any balance remaining unpaid at the termination of such period will be paid after receipt of documentation.
- Any benefits payable on behalf of your dependents after your death will be paid to your surviving Spouse, or at the option of the Trustees, directly to any hospital or person having a claim for services rendered to any legal guardian of your dependents.

KEEP A COPY!

It's always a good idea to keep copies of your bills for medical expenses. You should keep separate records of medical expenses, deductibles and maximum benefits as they apply to each Covered Individual in your family.

WORKERS' COMPENSATION CLAIMS

The Plan does not pay benefits for work-related Illness or injury. Those claims are covered under workers' compensation laws. If your injury or Illness is work related, you should file a claim with your Employer and/or the appropriate workers' compensation carrier. However, during the period your workers' compensation claim is under review or your claim has been denied by the workers' compensation carrier, the Plan may provide temporary benefits. In order for such benefits to be considered, the Plan must receive a copy of your workers' compensation claim determination stating whether your claim is under review or has been denied as non-work related, and a fully executed Reimbursement Agreement (supplied by the Plan) from you stipulating that all benefits paid by the Plan for the work-related condition will be refunded, in full, to the Plan by the workers' compensation carrier and/or yourself. Submission of the Reimbursement Agreement and supporting documentation is subject to review and is not a guarantee that related benefits will be issued.

You must keep the Plan informed of the status of your workers' compensation claim and you must immediately notify the Plan regarding the outcome of the claim. If you do not notify the Plan of the outcome, the Plan will contact the workers' compensation carrier or other third party to learn the outcome.

The Plan will provide documentation of the amount of benefits paid on your behalf by the Plan to the workers' compensation carrier for reimbursement upon request of the carrier or the Employee.

If you received weekly income benefits from this Plan for the work-related condition, you are responsible for reimbursing those benefits to the Plan, as well as any health benefits you received, from any monies received from any source in connection with your claim or your own funds.

If the workers' compensation carrier denies liability, or your claim is determined by the workers' compensation agency not to be work related, and no settlement is reached otherwise, sufficient supporting documentation is needed so that the Plan may continue to pay benefits relating to the condition, if any are payable.

The Plan will directly contact the workers' compensation carrier, or other third party, to verify the denial and to verify that an appeal has or has not been filed. If an appeal has been filed, you must keep the Plan informed of the status and the outcome of the appeal. A periodic follow-up will be done by the Plan to obtain the outcome of this appeal.

If no workers' compensation claim is filed, and it appears to the Plan that the condition is work related, no benefits will be paid for the work-related injury or Illness.

MEDICARE CLAIMS

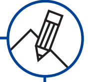
If you are eligible for Medicare, you should submit your medical claims to Medicare first and then submit a copy of the claim and the Explanation of Medicare Benefits (EOMB) to the Benefits Office for payment in the event Medicare has not paid the entire expense.

- Under Medicare Part A, a patient is eligible for 90 days of hospital care in a benefit period and may be eligible for as many as 150 days of hospital care in a benefit period if he/she draws on his/her lifetime reserve days.
- Under Medicare Part B, after satisfaction of an annual deductible, Medicare will pay participating providers 80% of the allowed charge for covered services.
- This Plan will not pay for charges for a private hospital room when Medicare coverage only provides for a semi-private room.

If a medical expense you incur is covered but Medicare does not pay the entire expense, you should submit your medical claim form and the Explanation of Medicare Benefits (EOMB) for payment to:

National Elevator Industry Health Benefit Plan
P.O. Box 910
Newtown Square, PA 19073-0910

NOTIFICATION OF INITIAL BENEFIT DETERMINATION



Applicable Definitions

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves "urgent care," is a "pre-service claim," or is a "post-service claim." These terms are defined in this section.

Urgent Care Claim

This is a claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your medical condition would subject you to severe pain if your claim were not dealt within the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim.

Pre-Service Claim

This is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim

This is any claim for a benefit that is not a pre-service claim. In this type of claim, you request reimbursement after medical care has already been rendered.

Concurrent Care Claim

This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

Urgent Care Claim

The Benefits Office will notify you whether your claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim, unless your claim is incomplete. The Benefits Office will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Benefits Office may notify you orally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Benefits Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

Pre-Service Claim

The Benefits Office will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Benefits Office require that additional time is needed to process your claim. If an extension is needed, the Benefits Office will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Benefits Office expects to reach a decision. If the Benefits Office needs an extension because you have submitted an incomplete claim, it will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Benefits Office may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Benefits Office to decide a claim, the period for making the benefit determination is tolled from the date on which the Benefits Office sent the notification of the extension until the date you respond to the request for additional information.

Post-Service Claim

The Benefits Office will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Benefits Office require that additional time is needed to process your claim. If an extension is needed, the Benefits Office will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the it expects to reach a decision. If the Benefits Office needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Benefits Office to decide a claim, the period for making the benefit determination is tolled from the date on which the Benefits Office sends you the notification of the extension until the date you respond to the request for additional information.

Concurrent Care

If the Benefits Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Benefits Office will notify you of its determination within 24 hours after receiving your claim, provided that it receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

DENIAL OF CLAIM FOR BENEFITS

If any claim for benefits described above is denied, in whole or in part, the Benefits Office (or an individual or entity acting on its behalf) will provide you with a written or electronic Explanation of Benefits notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination is based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning an urgent care claim, the Explanation of Benefits will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim, the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

APPEALS

General

If your claim for group health benefits is denied, in whole or in part, you may request the Board of Trustees to review the benefit denial. Your written appeal must be submitted within 180 days of receiving the denial notice. If the Benefits Office has approved an ongoing course of treatment to be provided over a period of time or number of treatments, it will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Benefits Office will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Benefits Office did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal is made by the Trustees or a designated committee of the Trustees, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Trustees or the designated committee of the Trustees deciding the appeal will give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

If the Trustees, or a designated committee of the Trustees, in the process of considering an appeal determine, based upon the medical information available that an otherwise non-covered service, procedure, treatment or equipment with respect to you is likely to achieve the same results as a more costly covered service, procedure, treatment or equipment, then the Trustees or committee of the Trustees, in their sole discretion, may elect to provide coverage for the less costly but otherwise non-covered expense in lieu of the more costly covered expense. In addition, the availability of coverage for alternative treatment in accordance with this provision will be limited to those circumstances in which the likelihood of a cost saving to the Plan can be clearly identified. The Trustees may establish limits and review requirements with respect to each individual coverage determination.

Also, in the case of an urgent care claim, you may request review orally or in writing, and communications between you and the Plan may be made by telephone, facsimile, or other similar means.

NOTIFICATION OF DECISION ON APPEAL

Timing of Notification for an Urgent Care Claim

The Trustees will notify you of their decision of an urgent care claim as soon as possible, but not later than 72 hours after receiving your request for review.

Timing of Notification for a Pre-Service Claim

The Trustees will notify you of their determination of a pre-service claim within a reasonable period of time, but not later than 30 days after receiving your request for review.

Timing of Notification for a Post-Service Claim

In the case of a post-service claim, the Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal was received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

Content of Notification

The Plan will provide you with written or electronic notice of its determination on review. The notice will set forth the specific reason(s) for the adverse determination, the specific Plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Trustees' Decision on Appeal is Final and Binding

The decision of the Trustees on review is final and binding upon all parties including any person claiming a benefit on your behalf. The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including,* but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

CLAIMS AND APPEALS FOR WEEKLY INCOME BENEFITS

To file a claim for weekly income benefits, you must contact the Benefits Office. See page 73 for more information. In addition, the following procedures apply.

Notification of Initial Benefit Determination

The Benefits Office will decide claims for weekly income benefits within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Plan if the Benefits Office notifies you of the extensions prior to the expirations of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for the Benefits Office to decide a claim, the period for making the benefit determination is tolled from the date on which the Benefits Office sends you the notification of the extension until the date you respond to the request for additional information.

*However, see the section entitled "Your AD&D Benefits At-A-Glance" on page 65 which explains that the insurance carrier providing the AD&D coverage is the sole and only decision-maker on loss eligibility claims.

Denial of Claim for Benefits

If your application for benefits is denied, in whole or in part, the Benefits Office will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you

will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

Appeals

If your claim is denied, you may request the Board of Trustees to review the benefit denial by submitting a written appeal to the Trustees. Your written appeal must be submitted within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Benefits Office will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Benefits Office did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal is made by the Trustees or a designated committee of the Trustees, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Trustees or designated committee of the Trustees deciding the appeal will give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

Notification of Decision on Appeal

The Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal is received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

Content of Notification

This notice will set forth the specific reason(s) for the adverse determination, the specific Plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination and a statement of your right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. The decision of the Trustees on review shall be final and binding upon all parties including any person claiming a benefit on your behalf.

Trustees' Decision on Appeal is Final and Binding

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

CLAIMS AND APPEALS FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

To file a claim for life insurance or accidental death and dismemberment benefits, you must follow all of the procedures explained on page 73. In addition, the following procedures apply. Life Insurance and accidental death and dismemberment benefits will be paid in accordance with the terms of the provisions of the insurance contract by the insurance company that provides the coverage for these benefits.

Denial of Claim for Benefits

If your claim for benefits is denied, in whole or in part, the Benefits Office will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA.

This notice will be given to you within a reasonable time but not more than 90 days after your claim is received by the Benefits Office. This 90-day period may be extended for up to an additional 90 days if special circumstances require that additional time is needed to process your claim. If an extension is needed for the Benefits Office to process your claim, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which the Benefits Office expects to make a decision. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

Appeals

If your claim is denied, you may request the Board of Trustees to review the benefit denial by submitting a written appeal to the Trustees. Your written appeal must be submitted within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Benefits Office will be final and binding. Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Benefits Office did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

Timing of Notification of Decision on Appeal

The Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal is received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following the Benefits Office's receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring an extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

Content of Notification

This notice will set forth the specific reason(s) for the adverse determination, the specific Plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under Section 502(a) of ERISA. The decision of the Trustees is final and binding upon all parties including the claimant and any person claiming a benefit on behalf of the claimant.

Trustees' Decision on Appeal is Final and Binding

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. However, regarding Accidental Death and Dismemberment (AD&D) benefits, loss eligibility is determined by the insurance carrier providing the AD&D benefit under the terms of the policy with the Plan.* If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

Plan Policies, Determinations or Actions

If you disagree with a policy, determination or action of the Plan, you may request the Trustees to review the Plan policy, determination or action with which you disagree by submitting a written appeal to the Trustees. Your written appeal must be submitted within 60 days after you learn of a Plan policy, determination or action with which you disagree and which is not a benefits denial.

Your written appeal should state the reasons for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a policy, determination, or action. The Trustees can best consider your position if they understand your claims, reasons and/or objections.

*See the section entitled "Your AD&D Benefits At-A-Glance" on page 65 which explains that the insurance carrier providing the AD&D coverage is the sole and only decision-maker on loss eligibility claims.

The Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal is received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following the Benefits Office's receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review, you will be notified in writing.

The Trustees have full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits, except as provided under the AD&D Benefits explained on pages 65 and 80.

If the Trustees deny your appeal of a claim or challenged policy, determination or action, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

General Information on Claims and Appeals

You may designate a representative to act on your behalf in filing a claim or an appeal of a denial of a claim or other adverse determination. If the Benefits Office or Trustees are uncertain whether or not you have designated a representative, they either may request that you put such designation in writing and may decline to communicate with a third party claiming to be a representative until such written designation is received.

All determinations of initial claims and appeals will be made in accordance with the Plan document, policies and rules and will apply the Plan provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

Throughout the procedures set forth above, there are several time limits within which a claimant must file a claim or appeal and within which the Benefits Office or the Trustees must issue a decision on such claim or appeal. The Benefits Office or the Trustees may agree to extend the time limits within which the claimant must file and the claimant may agree to extend any time limit within which the Benefits Office or the Trustees must issue a decision. The agreement to extend a time limit must be knowing, explicit, and confirmed in writing before the time period in question expires.

Plan Facts

Name of Plan	National Elevator Industry Health Benefit Plan
Type of Plan	An Employee Health and Welfare Benefit Plan that provides medical care, dental, vision, weekly income, life insurance and accidental death and dismemberment benefits to eligible Employees. Qualified dependents are eligible for medical, dental and vision benefits.
Name of Plan Sponsor	Board of Trustees National Elevator Industry Health Benefit Plan
Benefits Office Address	19 Campus Blvd., Suite 200 Newtown Square, PA 19073
Benefits Office Phone Number	1-800-523-4702
Benefit Plan Website	www.neibenefits.org
Agent for Service of Legal Process	Board of Trustees
Plan Administrator	Board of Trustees. The Plan's Restated Agreement and Declaration of Trust vests the Board of Trustees with full discretionary authority to adopt a written Plan of Benefits, and the detailed basis on which payment of benefits is to be made pursuant to the Restated Agreement and Declaration of Trust is set forth in the Plan of Benefits. The Board of Trustees has adopted this National Elevator Industry Health Benefit Plan Summary Plan Description, along with and any amendments hereto, to serve as this Plan of Benefits.
Plan Number	501
IRS Employer Identification Number (EIN)	23-6209407
Plan Fiscal Year	January 1-December 31
Source of Contributions to the Plan	Employer contributions as established by the Collective Bargaining Agreements, and Employee contributions through wage deductions and Employee self-pay contributions as established by the Trustees.

Organizations Through Which Plan Benefits are Provided

- **Medical Care:** Blue Cross Blue Shield BlueCard PPO Program
- **Mental Health and Substance Abuse:** Beacon Health Options
- **Prescription Drugs:** Express Scripts
- **Vision Care:** EyeMed Vision Care
- **Dental Care:** The Guardian Insurance Company (Optional PPO)
- **Hearing Care:** Audio*NET*America
- **Life Insurance and Accidental Death and Dismemberment Insurance:** Amalgamated Life Insurance Company

Plan Termination and Amendment

The Trustees reserve the right to suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the group insurance policy (for Life Insurance and Accidental Death and Dismemberment Insurance) and the Agreement and Declaration of Trust establishing the Plan.

The Trustees expect that the Plan will continue indefinitely. However, the Trustees do have the right to terminate the Plan if there is no longer a Collective Bargaining Agreement requiring contributions to the Plan. In the unlikely event that the Plan terminates, the Trustees would continue to apply the assets to provide health and related benefits to covered members, retired members, and their dependents in accordance with the terms of the Plan in effect at that time including any Plan changes adopted by the Trustees in connection with the Plan termination. In the event of termination, the Trustees will also apply the assets of the Trust to pay termination expenses, file reports and give notices as required by law.

Plan Liability

Use of the services of any hospital, clinic, Physician or other provider rendering health care, whether designated by the Plan or otherwise, is the voluntary act of you or your family. Even if some benefits may only be obtained from providers designated by the Plan, this is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees of the Plan.

The Plan makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with the Plan coverage. The provider is solely responsible for the services and treatments rendered.

CONFIDENTIALITY AND PROTECTION OF YOUR HEALTH INFORMATION

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers or third parties. Protected health information will only be disclosed to the extent authorized by the patient; as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or as otherwise authorized or required by law. The Plan has adopted certain written rules and policies to ensure that with regard to its use, disclosure and maintenance of protected health information, it complies with applicable law.

You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Benefits Office. You may also cancel any previous written authorization you have provided the Plan by submitting a written cancellation of authorization to the Benefits Office. You may request these forms from the Benefits Office.

The Plan has provided Participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the notice or would like additional information about the Plan's use and disclosure of protected health information or your rights with regard to this information, you may request a copy of the notice from the Benefits Office.

Your ERISA Rights

As a covered member in the National Elevator Industry Health Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Benefits Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Trustees, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Trustees may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each Participant with a copy of this summary annual report.

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trustees. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Glossary of Terms

When the following terms are used in this booklet, these definitions apply.

Active Member: An Active Member means the persons in the following groups employed by Employers who are required to make contributions to the Plan and make these contributions in accordance with the current NEBA Agreement with the International Union of Elevator Constructors or other collective bargaining agreements of the IUEC or its local unions or participation agreements between the Employer and the Trustees:

1. Elevator constructor mechanics, helpers, apprentices and assistant mechanics in the employ of Employers;
2. Elected or appointed officers and employees of the International Union of Elevator Constructors;
3. Paid employees of the National Elevator Industry Educational Plan;
4. Paid employees of the National Elevator Industry Pension Plan;
5. Paid employees of the Local Unions of the International Union of Elevator Constructors;
6. Paid employees of the Elevator Industry Work Preservation Fund; and
7. Other groups that the Trustees agree may participate that are covered by a participation agreement.

The following persons are also considered "elevator constructor mechanics and helpers" and must participate in the Health Benefit Plan:

1. A person who directly or indirectly holds more than one-half of one percent (0.5%) of the stock of any Employer which is required to make contributions to the Plan that is incorporated (or one-half of one percent (0.5%) of the ownership interest of any Employer which is required to make contributions to the Plan that is a limited liability company) if that person is performing bargaining unit work for that Employer, in which case contributions, at the rate of a minimum of 165 hours per month, must be made by the Employer on behalf of such person. The reporting of a minimum of 165 hours for contributions will commence with the date the person first acquires ownership interest and will continue thereafter for every month regardless of the hours actually worked in any month. Notwithstanding the foregoing, if the person works for another Employer which makes contributions to the Plan on the person's behalf, and the corporation or limited liability company in which the person holds an ownership interest is inactive, the corporation or limited liability company does not have to make contributions at the minimum rate of 165 hours on behalf of the person.
2. Any person who is an officer or other official of an Employer which is a corporation or limited liability company which is required to make contributions to the Plan, including an owner of a corporation or limited liability company described in number 1, above, if that person is performing bargaining unit work for that Employer, in which case contributions, at the rate of a minimum of 165 hours each month, must be made by the Employer on behalf of such officer or other official. The reporting of a minimum of 165 hours for contributions will commence with the date the person first becomes an officer or other official and will continue thereafter for every month regardless of the hours actually worked in any month. If the officers or other officials of the Employer work for another Employer which is required to make contributions to the Plan on the officer's or other official's behalf, and the Employer is inactive, the Employer does not have to make contributions at the minimum rate of 165 hours on behalf of the officers and other officials.

An owner of an Employer which is unincorporated (other than the owner of a limited liability company) is not considered an Active Member and may not participate in the Plan.

An Active Member is also an Employee who currently is not engaged in covered employment but who is Disabled or laid-off and continues to maintain eligibility for benefits in accordance with the Plan's extended benefits provisions. However, a former Employee who is eligible for benefits under COBRA Continuation Coverage is not an Active Member.

Ambulatory Surgical Center: An ambulatory surgical center is a specialized facility:

- Where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
- Where coverage of such facility is not mandated by law, but meets all of the following requirements:
  - It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located, primarily for the purpose of performing surgical procedures;
  - It is operated under the supervision of a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital (as defined) in the area;
- It requires that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure in all cases except those requiring only local infiltration anesthetics;
- It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available trained personnel and necessary equipment to handle foreseeable emergencies, including, but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply;
- It provides the full-time services of one or more Registered Graduate Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room;
- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- It maintains an adequate medical record for each patient; such record is to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history, and laboratory tests and/or x-rays, an operative report, and a discharge summary.

Birth Center: A birth center is a specialized facility:

- Where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
- Where coverage of such facility is not mandated by law, meets all of the following requirements:
  - It is primarily a place for delivery of children following a normal, uncomplicated pregnancy, that is operated and equipped in accordance with all applicable state laws;
  - It is equipped to perform routine diagnostic and laboratory examinations, such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;
  - It has available trained personnel and necessary equipment to handle foreseeable emergencies, including, but not limited to, oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - It is operated under the full-time supervision of a duly licensed Physician who is a doctor of medicine (M.D.) or registered graduate nurse (R.N.);
  - It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications; and
  - It maintains an adequate medical record for each patient; such record is to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary.

Child(ren): The term "children" includes your biological children, your stepchildren, your legally adopted children or children placed with you for adoption.

Chiropractic Services: Chiropractic Services are services provided by a licensed chiropractor that are:

- permitted by law to be provided by such provider;
- essential and appropriate for the diagnosis and treatment of an Illness or injury to the neuromusculoskeletal system;
- broadly accepted by the standards of the chiropractic industry;
- therapeutically safe;
- clinically effective;
- appropriate for the patient's age and presenting condition; and
- not considered to be investigative or Experimental.

Convalescent/Rehabilitation/Long-Term Acute Care Facility: A convalescent/rehabilitation/long-term acute care facility is a skilled nursing facility:

- As the term is defined in the Medicare provisions of the Social Security Act, which is qualified to participate and eligible to receive payments under and in accor dance with the provisions of Medicare, except for a skilled nursing facility that is part of a hospital;
- An institution which fully meets all of the following requirements:
  - It is operated in accordance with the applicable laws in the jurisdiction in which it is located;
  - It is operated under the supervision of a duly licensed Physician or registered graduate nurse (R.N.), who is devoting full-time to such supervision;
  - It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care for sick and injured persons at the patient's expense during the convalescent stage of an injury or Illness;
  - It maintains a daily medical record for each patient who is under the care of a duly licensed Physician;
  - It is authorized to administer medication to patients on the order of a duly licensed Physician;
  - It is not, other than incidentally, a home for the aged, blind, or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics, substance abusers, or the mentally ill; and
  - It is not a hospital, or part of a hospital.

Copay (or Copayment): Your copayment is the total amount you are required to pay when:

- a covered Prescription Drug is filled;
- utilizing an EyeMed provider for vision benefits; or
- utilizing an emergency room.

Cosmetic: Cosmetic refers to the alteration of tissue mainly for the improvement of appearance.

Covered Expenses: Covered expenses are expenses that are covered under the Plan.

Covered Individuals: A Covered Individual is an individual who is entitled to receive benefits under the Plan as an Active Member including an Active Member who is receiving extended benefits through the Plan, a Retired Employee, eligible dependent, or a Participant or dependent who is receiving benefits under COBRA Continuation Coverage.

Custodial Care: Custodial Care relates to services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial Care also can include medical services given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Care services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Dentist: An individual duly licensed to practice dentistry by the governmental agency having authority over the licensing and practice of dentistry where the service is rendered. A dentist includes a Physician furnishing dental care where he or she is licensed.

Disability Retiree: A Disability Retiree is a Retiree who is receiving a disability pension from the National Elevator Industry Pension Plan, the IUEC Officers and Employees Pension Plan or the National Elevator Industry Fund Office Employees Defined Benefit Pension Plan.

Early Retiree: An Early Retiree is a Retiree other than a Disability Retiree who begins receiving a pension from the National Elevator Industry Pension Plan, the IUEC Officers and Employees Pension Plan or the National Elevator Industry Fund Office Employees Defined Benefit Pension Plan before age 65.

Employee: See definition of Active Member on page 7 and 87.

Employer: An Employer is:

- Any employer who meets the definition of "Employer" under the National Elevator Industry Health Benefit Plan Trust Agreement and is bound by a collective bargaining agreement with the IUEC or any IUEC local union providing for contributions to the Plan.
- An employer who employs elevator constructor mechanics and helpers represented by the IUEC or local unions of the IUEC, to run temporary cars, that is contractually obligated by a signed stipulation to make contributions.
- Local unions of the IUEC.
- The IUEC.
- The National Elevator Industry Educational Program.
- The National Elevator Industry Pension Plan as the consolidated employer of the employees of the NEI Pension Plan, NEI Health Benefit Plan and Elevator Constructors Annuity and 401(k) Retirement Plan.
- Elevator Industry Work Preservation Fund.
- Other employers if the Trustees approve their participation

You may obtain information as to whether any particular employer is an Employer by writing the Benefits Office. You may also obtain a list of the subsidiary Employers upon written request; it is also available for inspection at the Benefits Office.

Experimental Treatment or Service: An Experimental Treatment or Service is any medical or dental service or supply that is still under study and is not recognized as safe and effective for diagnosis or treatment of Illness or injury.

Home Health Care Agency: A Home Health Care Agency is an agency or organization that provides a program of home health care and that:

- Is approved as a home health care agency under the provisions of Medicare; or
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; or
- Meets all of the following requirements:
  - An agency that holds itself forth to the public as having the primary purpose of providing a home health care delivery system, bringing supportive services to the home;
  - Has a full-time administrator;
  - Maintains written records of services provided to the patient;
  - Staff includes at least one registered graduate nurse (R.N.) or it has nursing care by an R.N. available; and
  - Employees are bonded and are provided malpractice and malplacement insurance.

Hospice: A Hospice is an agency that provides counseling and incidental medical services and may provide Room and Board to a terminally ill person and that meets all of the following requirements:

- Has obtained any required state or governmental Certificate of Need approval;
- Provides 24-hour/7-day service;
- Is under the direct supervision of a duly licensed Physician;
- Has a nurse coordinator who is a registered graduate nurse (R.N.) with four years of full-time clinical experience, at least two years of which involved caring for terminally ill patients;
- Has a social service coordinator who is licensed in the jurisdiction in which it is located;
- Is an agency that has as its primary purpose the providing of hospice services;
- Has a full-time administrator;
- Maintains written records of services provided to the patient;
- Its employees are bonded and are provided malpractice and malplacement insurance; and
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

Hospital: An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the requirements set forth below:

- A hospital accredited by the Joint Commission on Accreditation of Hospitals;
- A hospital, psychiatric hospital, or a tuberculosis hospital, as those terms are defined in the provisions of Medicare, that is qualified to participate and eligible to receive payments under, and in accordance with, the provisions of Medicare;
- An institution that fully meets all of the following requirements:
  - Maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by, or under the supervision of, a staff of duly licensed Physicians.
  - Continuously provides on the premises 24-hour-a-day nursing service by, or under the supervision of, Registered Graduate Nurses (R.N.); and
  - Is operated continuously with organized facilities for operative surgery on the premises.

Hospital Services and Supplies: Hospital Services and Supplies are those services and supplies that are furnished to the person, other than Room and Board, the professional services of any Physician and any private duty or special skilled nursing services (including intensive nursing care by whatever name it is called), regardless of whether such services are rendered under the direction of the Hospital or otherwise.

Illness: The term Illness includes, but is not limited to:

- a disease or disorder resulting in an unsound condition of the mind or body;
- a surgical procedure performed for the purpose of sterilization and necessary medical care, treatment, and confinement from and in connection with such procedure;
- pregnancy or related conditions.

The term Illness used in connection with newborn children includes, but is not limited to:

- congenital defects and birth abnormalities including premature births.

Lifetime Maximum: The Lifetime Maximum is the amount payable for the benefit, service or supply during your lifetime.

Marriage: Marriage means a legal union between two persons recognized under the laws of a state in the United States as married with a legally valid marriage certificate.

Medical Necessity or Medically Necessary: Medically Necessary services are covered services that a Physician or other health care provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an Illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's Illness, injury or disease;
- not primarily for the convenience of the member, Physician, or other health care provider and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's Illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Midwife: A Midwife is a person who has an active license to practice midwifery granted by a state board of health.

Nurse-Midwife: A Nurse-Midwife is a person who is certified to practice as a nurse-midwife and fulfills both of the following requirements:

- Licensed by a board of nursing as a registered graduate nurse (R.N.) and;
- Completion of a program approved by the state for the preparation of nurse-midwives.

Any services provided in a birth center by a licensed Midwife or a licensed Nurse-Midwife acting within the scope of that license will be payable on the same basis as services that are provided by a duly licensed Physician. Charges from a Nurse-Midwife are payable in lieu of charges from a duly licensed Physician.

Optometrist: An optometrist is a person duly licensed to practice optometry by the governmental authority having jurisdiction over the licensing and practice of optometry in the locality where the service is rendered.

Orthodontia or Orthodontics: Orthodontia is the field of dentistry involved in the care and treatment of misaligned teeth.

Orthodontist: An Orthodontist is a Dentist specializing in treatment of Orthodontia or Orthodontics.

Participant: A Participant is an Active Member, a Retired Employee or a former Active Member who is eligible for benefits through COBRA Continuation Coverage and who, to the extent required by the terms of this SPD, has timely elected to receive coverage under the Plan and has paid the required premiums for coverage.

Participating Pharmacy: A Participating Pharmacy is a pharmacy in the Express Scripts network that accepts the plastic identification card and will fill the prescription and charge only the appropriate Copayment.

Physician: A Physician is a duly licensed doctor who is practicing within the scope of his or her license.

Plan: The Plan is the National Elevator Industry Health Benefit Plan.

Prescription Drug: A Prescription Drug is a drug that, under federal or state law, may be dispensed only upon prescription by a duly licensed physician and which is dispensed to the Covered Individual by prescription of a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice.

Primary Plan: The Primary Plan is the insurance coverage or plan that pays first.

Retired Employee or Retiree: A Retired Employee or Retiree is a former Employee of an Employer who has established his or her effective date of pension under the National Elevator Industry Fund Office Employees Defined Benefit Plan, the National Elevator Industry Pension Plan or the International Union of Elevator Constructors Officers and Employees Pension Plan. A retired employee whose pension benefits have been suspended under the terms of the NEI Pension Plan for employment, other than for a contributing employer, will no longer be considered a retired employee for purposes of this Plan (see page 18).

Room and Board: Room and Board includes a patient's room, board, general duty nursing, and any other services regularly furnished by the hospital as a condition of the class of accommodations occupied, but not including professional services or Physicians nor intensive nursing care by whatever name it is called.

Charges for intensive care unit accommodations are deemed to be charges for Room and Board up to the hospital's charges for such accommodations.

Secondary Plan: The Secondary Plan is the insurance coverage or plan that pays second (after the Primary Plan has paid).

Skilled Nursing Services: Skilled Nursing Services are the services of a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), and a licensed or certified Midwife, Nurse-Midwife or nurse-practitioner acting within the scope of that license or certification when Medically Necessary and prescribed by a duly qualified Physician. Skilled Nursing Services include anesthesia performed by a nurse when a Covered Individual is undergoing surgery and a charge is also made by an anesthesiologist, but the charges are prorated based on the level of services rendered by each involved practitioner. Skilled Nursing Services do not include services performed during hospitalization.

Social Worker: A Social Worker is a person specializing in clinical social work and is a licensed social worker (L.S.W.) who is licensed in the jurisdiction in which services are rendered or certified as a social worker by the appropriate authority.

Spouse: A Spouse refers to a person recognized under the laws of a state in the United States as being legally married to you and as documented with a legally valid marriage certificate.

UCR Rate: The UCR Rate (also known as the Usual, Customary and Reasonable Rate) is the lesser of:

1. the amount the provider charged the patient for services or supplies, or
2. the usual fee charged to most patients for similar services or supplies that falls within the range charged by providers with comparable training and experience for the same or similar services or supplies within the same geographic area.

UCR Rates as defined in 2 above are established by an independent group contracted by the Plan which maintains a national database of UCR Rates. In addition, secondary PPO networks and negotiated rates may be utilized if they result in lower costs to the Plan or Covered Individual.

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